1011

Gilmore
Ellis

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

00984

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place): 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Mairyland
COUNTY: Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Deal Island 19X-2
STREET ADDRESS (If rural give location): None ✓

3. NAME OF DECEASED: (First) ELNORA (Middle) (Last) ABBOTT
4. DATE OF DEATH: (Month) JAN (Day) 20 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed
8. DATE OF BIRTH: Feb. 18. 1881
9. AGE last birthday: 72 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House WiFe
10b. KIND OF BUSINESS OR INDUSTRY: At own Home
11. BIRTHPLACE (State or foreign country): Toddville Md.
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: OLIVER ROBINSON
14. MOTHER'S MAIDEN NAME: Maggie Robins
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) N (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: MRS. C. BAKER Webster (DAUGHTER) DEAL ISLAND Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause: (a) Cerebral Thrombosis
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO: (b) Cerebral Atherosclerosis
DUE TO: (c)
332X
Interval Between Onset And Death: (a) 2 days (b) Symptoms 4 yrs

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 19, 1954 to Jan. 20, 1954, that I last saw the deceased alive on Jan 20, 1954, and that death occurred at 11:29 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): David Gilmore M.D. ADDRESS: Camden Avenue Salisbury, Maryland DATE SIGNED: Jan 21 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial
DATE THEREOF: Jan. 23 1954
NAME OF CEMETERY OR CREMATORY: St. Johns Church Cem.
LOCATION (City, town, or county) (State): Deal Island, Maryland
DATE REC'D BY LOCAL REGISTRAR: 1-22-54
REGISTRAR'S SIGNATURE: Mary W. Holloway
24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY SALISBURY MARYLAND ADDRESS
Walter R. Holloway

M

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 25 1954
BUREAU V. S.

1012

00985

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND COUNTY WOR
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN 23X-2
STREET ADDRESS (If rural give location) R.F.D.

3. NAME OF DECEASED: (Type or Print) (First) Arthur (Middle) M. (Last) Adkins

4. DATE OF DEATH: (Month) JAN. (Day) 2 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) WIDOWER
8. DATE OF BIRTH: MAY 15, 1885
9. AGE last birthday: 68 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: PAINTER (RETIRED)
10b. KIND OF BUSINESS OR INDUSTRY: SELF EMPLOYED
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: WILLIAM ADKINS
14. MOTHER'S MAIDEN NAME: ELLEN SHOCKLEY

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: MR. CURTIS HICKS SNOW HILL, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

332X

Immediate cause (a) Cerebral Thrombosis — Interval Between Onset And Death: 1 month

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Cerebral Atherosclerosis

DUE TO (c) Myocardial Insufficiency — 6 months

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Malnutrition

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/14/1963, to 1/2, 1954, that I last saw the deceased alive on 1/2, 1953, and that death occurred at 12:30 pm, from the causes and on the date stated above.

SIGNATURE David J. Silvone M.D. (Degree or title) ADDRESS Salisbury Md. DATE SIGNED Jan. 2, 1953

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 1/5/54
NAME OF CEMETERY OR CREMATORY WHATCOAT
LOCATION (City, town, or county) SNOW HILL (State) MD
DATE REC'D BY LOCAL REGISTRAR 1-5-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Bruce A Burbage ADDRESS Berlin MD

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 7 1954
BUREAU V. S.

1012

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 00386

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
MARYLAND
LENGTH OF STAY (in this place) 4 DAYS
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE DELAWARE COUNTY SUSSEX
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN SEAFORD 46Y-5
STREET ADDRESS (If rural give location) OAK LANE; WESTVIEW ✓

3. NAME OF DECEASED: (Type or Print) (First) MAE (Middle) KATHRYN (Last) Baker

4. DATE OF DEATH: (Month) 1 (Day) 21 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: JULY 25, 1899

9. AGE last birthday: 54 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): NEW YORK

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: UNKNOWN

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: JACOB O. BAKER; SEAFORD, DELAWARE

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Artery Occlusion — Interval Between Onset And Death: 20 minutes

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Coronary Atherosclerosis

DUE TO

(c) Myocardial Insufficiency — 1 yr.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Rheumatic Heart Disease

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ....., 19....., to ....., 19....., that I last saw the deceased alive on ....., 19....., and that death occurred at 4 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) David F. Gilmore M.D. ADDRESS Salisbury Md. DATE SIGNED Jan. 21 1954

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF JAN 24, 1954

NAME OF CEMETERY OR CREMATORY ODD FELLOWS CEMETERY

LOCATION (City, town, or county) (State) SEAFORD, DELAWARE

DATE REC'D BY LOCAL REGISTRAR 1-25-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR ADDRESS MEDFORD L. WATSON JR.; SEAFORD, DEL.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 27 1954
BUREAU V. S.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY WICOMICO MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) FRUITLAND
LENGTH OF STAY (in this place) 18 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS FRUITLAND

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND WICOMICO
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FRUITLAND
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) ELIZABETH (Middle) EDNA (Last) BARRY

4. DATE OF DEATH: (Month) 1 (Day) 1 (Year) 1954

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): WIDOWED

8. DATE OF BIRTH: AUG. 20 1871

9. AGE last birthday: 82 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: HOUSE WIFE

10b. KIND OF BUSINESS OR INDUSTRY: OWN HOME

11. BIRTHPLACE (State or foreign country): ENGLAND

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: ROBERT HARDY

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No

(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Mrs FRANK HOUCK FRUITLAND

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause (a) Cerebral Hemorrhage — Interval Between Onset And Death: 1 Hr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Hypertension — 10 yrs.

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-1-48 to 1-1-54, 19..., that I last saw the deceased alive on 1-1-54, 19..., and that death occurred at 7 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Lee L Lowry M.D. ADDRESS Fruitland Md DATE SIGNED 1-1-54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

DATE THEREOF

NAME OF CEMETERY OR CREMATORY Hudson Cemetery

LOCATION (City, town, or county) (State) Hudson N.Y.

DATE REC'D BY LOCAL REGISTRAR 1-1-54

REGISTRAR'S SIGNATURE Maryll Holloway

24. FUNERAL DIRECTOR ADDRESS Hill & Johnson Co. Salisbury

George C Hill II

RECEIVED
JAN 5 1954
BUREAU V. S.

1014

# MARYLAND STATE DEPARTMENT OF HEALTH

00988

2411 N. Charles Street, Baltimore

# CERTIFICATE OF DEATH

Reg. Dist. No. 382

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH**
COUNTY Wicimico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury - 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp

**2. USUAL RESIDENCE (HOME) OF DECEASED**
STATE Md. — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
STREET ADDRESS (If rural, give location) 213 Pollito Lane

**3. NAME OF DECEASED** (Type or Print): (First) WILLIAM (Middle) M (Last) Battle

**4. DATE OF DEATH**: (Month) 1 (Day) 30 (Year) 1954

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | If under 1 year: Months | Days | If under 24 hrs.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| M | C | Wid | 1878 | 76 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Farmer | Farm | Va. | |

**13. FATHER'S NAME** Unknown

**14. MOTHER'S MAIDEN NAME** Unknown

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unknown) (If yes, give war or dates of service)

**16. SOCIAL SECURITY NO.**

**17. INFORMANT AND ADDRESS** James Battle

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — INTERVAL BETWEEN ONSET AND DEATH

331X

Immediate cause (a) Cerebral Haemorrhage

Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Hypertension & Arteriosclerosis

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| 0 | | Yes ☐ No ☐ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from Jan 28, 1954, to Jan 30, 1954, that I last saw the deceased alive on Jan 30, 1954, and that death occurred at 12:55 P m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Alfred Hearn MD 1130 Church St Salisbury 2/3/54

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | 2-5-54 | Green Acres Cem | Salisbury | Md |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 2-3-54 | Mary W. Holloway | Parker W. Lunch | Salisbury Md |

RECEIVED
FEB 5 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 331

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury R-4
LENGTH OF STAY (in this place) 10 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Allegany
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cumberland
STREET ADDRESS (If rural give location) 38 Humbird Street

3. NAME OF DECEASED: (First) PETER (Middle) J. (Last) BECKER
4. DATE OF DEATH: (Month) Jan. (Day) 8 (Year) 1954

| 5. SEX | 6. COLOR OR RACE | 7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify) | 8. DATE OF BIRTH | 9. AGE last birthday | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | Dec. 2, 1866 | 87 yrs. | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| None | -- | Cumberland, Md. | USA |

| 13. FATHER'S NAME | 14. MOTHER'S MAIDEN NAME |
|---|---|
| William Becker | Catherine Houck |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) | (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO. | 17. INFORMANT & ADDRESS |
|---|---|---|---|
| Unknown | -- | -- | Hospital Records |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) 465X acute Pulmonary edema due to — Interval Between Onset And Death: 36 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Pulmonary Infarction

DUE TO (c)

II OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Fracture of Femoral Neck — 3 years.

19a. DATE OF OPERATION: 0 | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/6 ,1953, to 1-8-54 1954, that I last saw the deceased alive on 1-8-54, and that death occurred at 9.00 AM from the causes and on the date stated above.

SIGNATURE Robert Jones (Degree or title) M.D. ADDRESS Peninsula Hosp. DATE SIGNED 1-8-54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial | DATE THEREOF Jan 11, 1954 | NAME OF CEMETERY OR CREMATORY Parsons Cemetery | LOCATION (City, town, or county) (State) Salisbury, Md.

DATE REC'D BY LOCAL REGISTRAR 1-8-54 | REGISTRAR'S SIGNATURE Mary W. Holloway | 24. FUNERAL DIRECTOR Holloway & Co. Salisbury, Md. ADDRESS

Walter R. Holloway

VS. A15

RECEIVED
JAN 11 1954
BUREAU V. S.

1015

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. William Smith

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 1
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 421 Pinehurst

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
STREET ADDRESS (If rural, give location) 421 Pinehurst

**3. NAME OF DECEASED:** (Type or Print) (First) HERMON (Middle) GEORGE (Last) BENEDICT

**4. DATE OF DEATH:** (Month) JAN (Day) 6 (Year) 1954

**5. SEX:** MALE Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): Married

**8. DATE OF BIRTH:** Sept. 19, 1892

**9. AGE last birthday:** 61 yrs. IF UNDER 1 YEAR: Months 3 Days 17 IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired Florist

**10b. KIND OF BUSINESS OR INDUSTRY:** Florist

**11. BIRTHPLACE** (State or foreign country): Utica New York

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** George Hermon Benedict

**14. MOTHER'S MAIDEN NAME:** Louise White

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mrs. Pearl Benedict (Wife) Salisbury, Maryland

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

INTERVAL BETWEEN ONSET AND DEATH

Immediate cause 4207.1 (a) Coronary Occlusion
DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) Hypertensive C.V. disease
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** 0

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ——, 19....., to ——, 19....., that I last saw the deceased alive on 1-6, 1954, and that death occurred at 5:30 A.m., from the causes and on the date stated above.

SIGNATURE Wm B. Smith (DEGREE OR TITLE) MD ADDRESS 222 North Division St. Salisbury, Maryland DATE SIGNED Jan 8 1954

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial - DATE THEREOF Jan. 8, 1954 NAME OF CEMETERY OR CREMATORY Parsons Cemetery LOCATION (City, town, or county) (State) Salisbury, Maryland

DATE REC'D BY LOCAL REG. 1-8-54 REGISTRAR'S SIGNATURE Mary W. Holloway

**24. FUNERAL DIRECTOR** HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

Walter R. Holloway

Walter R. Holloway

VS. A15 8-51

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11 1954

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct name is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury
LENGTH OF STAY (in this place) 4 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne R.F.D. #2
STREET ADDRESS (If rural give location) ✓

3. NAME OF DECEASED: (Type or Print) (First) Frank (Middle) (Last) Branford

4. DATE OF DEATH: (Month) 1 (Day) 3 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: May 7, 1886

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months / Days; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Carpenter

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Branford

14. MOTHER'S MAIDEN NAME: Margaret Revelle

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 213-12-5213

17. INFORMANT & ADDRESS: Mrs Frank Branford Princess Anne Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
019.2
Immediate cause (a) DUE TO Tuberculous Meningitis
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO Miliary Tuberculosis
(c)

Interval Between Onset And Death: 1 month and same

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-9, 1953 to 1-2, 1954 that I last saw the deceased alive on 1-3, 1954 and that death occurred at 1:35 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) William R. Ellis Jr. MD — ADDRESS Salisbury, Md. — DATE SIGNED 1-3-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-5-1954 — NAME OF CEMETERY OR CREMATORY St Andrew Cemetery — LOCATION (City, town, or county) (State) Princess Anne Md

DATE REC'D BY LOCAL REGISTRAR 1-4-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR — ADDRESS Leon R. Wilson Princess Anne, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Royer

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 2
HOSPITAL OR INSTITUTION OR STREET ADDRESS Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Mar yland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 531 Priscilla Street

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ELIZABETH (Last) BROWN

4. DATE OF DEATH: (Month) JAN (Day) 9 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: June 22, 1866
9. AGE last birthday: 87 yrs. IF UNDER 1 YEAR Months 6 Days 17 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) House Work
10b. KIND OF BUSINESS OR INDUSTRY: House Work at Home
11. BIRTHPLACE (State or foreign country): Wicomico County Maryland
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Hatter
14. MOTHER'S MAIDEN NAME: No Record

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mrs. Jerdie Brittingham (Daughter) R.D.# 5 Salisbury, Maryland

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Acute Congestive Heart Failure — Interval Between Onset And Death: one who

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arterio-sclerotic heart disease — years

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 2 Jan, 1954, to 9 Jan, 1954, that I last saw the deceased alive on 8 Jan, 1954, and that death occurred at 8:15 A.M., from the causes and on the date stated above.

SIGNATURE [signature] (Degree or Title) M.D. ADDRESS Camden Ave. Salisbury, Maryland DATE SIGNED Jan. 9 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 11, 1954
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) (State) Salisbury, Maryland
DATE REC'D BY LOCAL REGISTRAR 1-9-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY ADDRESS MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: Wicomico
COUNTY Somerset MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 1 mi
LENGTH OF STAY (in this place) 1 HR.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deal Island 1 mi S
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (First) Hobson (Middle) Burton (Last)
(Type or Print)

4. DATE OF DEATH: (Month) JANUARY (Day) 17 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: Dec-8-1898
9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Oysterman
10b. KIND OF BUSINESS OR INDUSTRY: oyster & crab
11. BIRTHPLACE (State or foreign country): Md - Deal Island
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN H BURTON
14. MOTHER'S MAIDEN NAME: EFFIE JONES

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service) No
16. SOCIAL SECURITY NO.: Unknown
17. INFORMANT & ADDRESS: Grace Burton Wife

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarct, acute — Interval Between Onset And Death: 1 hr.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Arteriosclerotic Coronary Thrombosis — 1 hr.
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: None
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-17., 19.54, to 1-17., 19.54 that I last saw the deceased alive on 1-17., 19.54, and that death occurred at 4:20 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
William R. Ellis Jr. M.D. Salisbury, Md 1-17-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/20/54
NAME OF CEMETERY OR CREMATORY St Johns MPE
LOCATION (City, town, or county) (State) Deal Island Md

DATE REC'D BY LOCAL REGISTRAR 1-20-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Webster
ADDRESS Deal Island

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 1 20
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne 1 yr
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Margaret (Middle) ✓ (Last) Calloway

4. DATE OF DEATH: (Month) January (Day) 29 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) ~~widowed~~
8. DATE OF BIRTH: June 15 1924
9. AGE last birthday: 29 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Crisfield Md
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Emory Nelson
14. MOTHER'S MAIDEN NAME: Marion Nelson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 9 (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT & ADDRESS: Elwood Calloway.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

201X

Immediate cause (a) Hodgkins Disease — Interval Between Onset And Death 1 yr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-4, 1954, to 1-29, 1954 that I last saw the deceased alive on 1-29, 1954, and that death occurred at 5 PM, from the causes and on the date stated above.

SIGNATURE David J. Gilmore (Degree or title) M.D. ADDRESS Salisbury Md. DATE SIGNED Jan. 29 1954

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF Jan 31, 1954
NAME OF CEMETERY OR CREMATORY Manokin Presbyterian
LOCATION (City, town, or county) Princess Anne (State) Md

DATE REC'D BY LOCAL REGISTRAR 1-30-54
REGISTRAR'S SIGNATURE Mary W Holloway
24. FUNERAL DIRECTOR James Hinman ADDRESS Princess Anne Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 1202 Lake Street

3. NAME OF DECEASED: (Type or Print) (First) Gertrude (Middle) (Last) Collins

4. DATE OF DEATH: (Month) January (Day) 22 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: 11-22-15

9. AGE last birthday: 38 yrs. IF UNDER 1 YEAR: Months 2, Days; IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At home

11. BIRTHPLACE (State or foreign country): Salisbury Wicomico Co. Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Edward Dashiell

14. MOTHER'S MAIDEN NAME: Carrie Horsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: None

17. INFORMANT & ADDRESS: James Collins, 1202 Lake St., Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

156.1
Immediate cause (a) Carcinoma of Liver DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) with metastasis to adjoining DUE TO

(c) Structures

Interval Between Onset And Death: 6 wks.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) Salisbury (COUNTY) Wicomico (STATE) Md

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec. 12, 1953, to Jan. 22, 1954, that I last saw the deceased alive on Jan. 22, 1954, and that death occurred at 2:PM., from the causes and on the date stated above.

SIGNATURE (Degree or title) G. Herbert Lemby MD ADDRESS Salisbury Md DATE SIGNED Jan 26, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1-26-54

NAME OF CEMETERY OR CREMATORY Green Acres Memorial Park

LOCATION (City, town, or county) Salisbury (State) Wicomico Co. Md.

DATE REC'D BY LOCAL REGISTRAR 1-25-54

REGISTRAR'S SIGNATURE Mary W. Holloman

24. FUNERAL DIRECTOR Mary A. Stewart ADDRESS 324 E. Church St.

STEWART FUNERAL HOME Salisbury, Maryland

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Royer

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS John B. Parsons Home for the Age.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
STREET ADDRESS (If rural, give location) ~~John B. Parsons Home for the Age~~

**3. NAME OF DECEASED:** (Type or Print) (First) Minnie (Middle) (Last) Courtney

**4. DATE OF DEATH:** (Month) Jan (Day) 27 (Year) 19 54

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): Widowed

**8. DATE OF BIRTH:** Nov. 26, 1863

**9. AGE last birthday:** 90 90 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Retired House Wife at Own Home

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Pocomoke, Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** C. Stephen Wilson

**14. MOTHER'S MAIDEN NAME:** Cordelia Caltin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Records (John B. Parsons Home for the Age)

**18. MEDICAL CERTIFICATION** Salisbury, Maryland

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:**

453.0

Immediate cause (a) Chronic Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: whs

DUE TO

Antecedent cause(s) (b) Arterio-Sclerosis — yrs

Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

DUE TO

(c)

**II. OTHER SIGNIFICANT CONDITIONS:** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** 0

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at 10:00 P m., from the causes and on the date stated above.

SIGNATURE Earl L Royer M.D. (DEGREE OR TITLE) ADDRESS Camden Avenue Salisbury, Maryland DATE SIGNED Jan. 28, 1954

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial

DATE THEREOF Jan. 29, 1954

NAME OF CEMETERY OR CREMATORY Whatcoat M. Cem.

LOCATION (City, town, or county) Snow Hill (State) Md.

DATE REC'D BY LOCAL REG. 1-29-54

REGISTRAR'S SIGNATURE Mary W. Holloway

**24. FUNERAL DIRECTOR** HOLLOWAY & COMPANY SALISBURY ADDRESS MARYLAND

Walter R. Holloway Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 336

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar X
LENGTH OF STAY (in this place) 37 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 708 State St X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar X
STREET ADDRESS (If rural give location) 708 State St

3. NAME OF DECEASED: (Type or Print) (First) JAMES (Middle) (Last) DAILEY

4. DATE OF DEATH: (Month) 1 (Day) 29 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: 10-5-1873
9. AGE last birthday: 80 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Machinist
10b. KIND OF BUSINESS OR INDUSTRY: Railroad
11. BIRTHPLACE (State or foreign country): Philadelphia Pa
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) ?
16. SOCIAL SECURITY No.: 213-24-4247
17. INFORMANT & ADDRESS: Annie Daily. Delmar Del

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

500X Immediate cause (a) Bronchitis subacute, Broncho pneumonia 4 weeks
DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO

260X (c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Diabetes mellitus Arteriosclerosis generalized arteriosclerotic heart disease ?

19a. DATE OF OPERATION: ?
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1950, 19 ..., to Jan 29, 1954, that I last saw the deceased alive on Jan 29, 1954, and that death occurred at 9:00 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) J. W. Bohler MD. ADDRESS Delmar Md. DATE SIGNED 1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried
DATE THEREOF 1-31-54
NAME OF CEMETERY ~~OR CREMATORY~~ Mt Olive
LOCATION (City, town, or county) Delmar Del. (State)
DATE REC'D BY LOCAL REGISTRAR January 31, 1954
REGISTRAR'S SIGNATURE Harry E Hudson Sr
24. FUNERAL DIRECTOR W. S. Marvel Co ADDRESS Delmar, Del

RECEIVED
FEB 1954
BUREAU V. S.

1955

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL, and give nearest town) OR TOWN Nanticoke X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN X Nanticoke
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Oscar (Middle) C. (Last) Dashield

4. DATE OF DEATH: (Month) Jan. (Day) 9 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 2 1882

9. AGE Last birthday: 71 yrs. IF UNDER 1 YEAR: Months Days; IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Waterman

10b. KIND OF BUSINESS OR INDUSTRY: Waterman

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: John Dashield

14. MOTHER'S MAIDEN NAME: Leah Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Annie Dashield, Nanticoke, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cardiac Failure — Interval Between Onset And Death: 1 week

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Hypertension, Arterio sclerotic Heart Disease — 4 years.
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. Ingestion — 2 weeks

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/1/54, to 1/9/54, that I last saw the deceased alive on 1/8, 1954, and that death occurred at 4:30 PM from the causes and on the date stated above.

SIGNATURE Reuel H. Saunders (Degree or title) M.D. ADDRESS Nanticoke Md. DATE SIGNED 1/12/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan. 13, 1954 — NAME OF CEMETERY OR CREMATORY Nanticoke Cemetery — LOCATION (City, town, or county) Nanticoke (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-13-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Leven R. Wilson — ADDRESS Princess Anne, Md.

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp 26

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Delaware — COUNTY Sussex
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Selbyville Rural
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Lillie (Middle) A. (Last) Derrickson

4. DATE OF DEATH: (Month) 1 (Day) 19 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Oct. 1871

9. AGE last birthday: 82 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housework

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Snyder

14. MOTHER'S MAIDEN NAME: Louise Snyder

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Samuel Derrickson Selbyville, Del.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarct, acute — Interval Between Onset And Death: 18 hrs.

DUE TO

Antecedent causes (b) arteriosclerotic heart disease — Interval Between Onset And Death: 11

Antecedent causes: Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... ....., 19..... ....., to ..... ....., 19 , that I last saw the deceased alive on ..... ....., 19....., and that death occurred at 8:10 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) Wilbur R. Ellis, M.D. ADDRESS Salisbury Md. DATE SIGNED 1-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/23/54 — NAME OF CEMETERY OR CREMATORY Fernwood Cemetery — LOCATION (City, town, or county) Philadelphia (State) Pa.

DATE REC'D BY LOCAL REGISTRAR 1-20-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Watson & Gray — ADDRESS Frankford, Del.

VS. A15

1084

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

— MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH: Salisbury, Md.
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 13 -
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Clara
STREET ADDRESS (If rural give location) --

3. NAME OF DECEASED: (Type or Print) (First) Martha (Middle) Jane (Last) Dickey

4. DATE OF DEATH: (Month) 1 (Day) 5 (Year) 19 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Single

8. DATE OF BIRTH: May 15, 1878

9. AGE last birthday: 75 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: --

11. BIRTHPLACE (State or foreign country): Clara, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Thomas McKeen Dickey

14. MOTHER'S MAIDEN NAME: Sarah Jane Moore

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Unk. (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) 334X Arteriosc. cerebral — Interval Between Onset And Death: ?

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — DUE TO (b) Arteriosc. generalized

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosc. heart disease — ?

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION —

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) —

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 10/24/19 50 to 1/5/19 54 that I last saw the deceased alive on 1/5/19 54, and that death occurred at 5:45 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) M. D. ADDRESS Salisbury Md. Deer's Head State Hosp. DATE SIGNED 1/5/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1-7-1954 — NAME OF CEMETERY OR CREMATORY Oak Grove Cemetery — LOCATION (City, town, or county) Jesterville, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-7-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Vernon R. Wilson — ADDRESS Princess Anne, Maryland

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JAN 11 1954
BUREAU V. S.

1025

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 56

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND Md.
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
LENGTH OF STAY (in this place) 25 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 612 Westover Circle

3. NAME OF DECEASED: (Type or Print) (First) Riley (Middle) (Last) Dutton
4. DATE OF DEATH: (Month) January (Day) 24 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: Colored.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow
8. DATE OF BIRTH: June – 1898
9. AGE last birthday: 55 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Mill Wk. Labor.
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Allen
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Dutton
14. MOTHER'S MAIDEN NAME: Charolett Byrd.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 214-12-5088
17. INFORMANT & ADDRESS: Elizabeth Gunther

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis Arteriosclerosis — Interval Between Onset And Death 1/2 hr.

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerosis — Unknown

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Urethral Stricture — 6 mos

19a. DATE OF OPERATION: 2
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☑ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan 18, 1954, to Jan 24, 1954, that I last saw the deceased alive on Jan 24, 1954, and that death occurred at 6.30 pm, from the causes and on the date stated above.

SIGNATURE (Degree or title) Hans R. Mann MD
ADDRESS Salisbury Md
DATE SIGNED 1/26-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-29-1954
NAME OF CEMETERY OR CREMATORY Green Acres Cem
LOCATION (City, town, or county) (State) Salisbury Md.

DATE REC'D BY LOCAL REGISTRAR 1-29-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Booker M Loesch
ADDRESS

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 6716 Maine St

3. NAME OF DECEASED: (Type or Print) (First) (Middle) (Last) Gordy

4. DATE OF DEATH: (Month) (Day) (Year) June 16 1954

5. SEX: male

6. COLOR OR RACE: colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: 1/16/54

9. AGE last birthday: yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours 4 Min. 25

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME: Grace Mabelline Gordy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Grace Mabelline Gordy

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

776X

Immediate cause (a) Prematurity

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/16/ 1954, to 1/16, 1954 that I last saw the deceased alive on 1/16, 1954, and that death occurred at 5:10 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Robert Lee Baker MD ADDRESS Salisbury Md DATE SIGNED 1-16

23. BURIAL, CREMATION, REMOVAL (Specify) DATE THEREOF 1-16-54 NAME OF CEMETERY OR CREMATORY Peninsula General Hospital LOCATION (City, town, or county) Salisbury, Wicomico (State) md.

DATE REC'D BY LOCAL REGISTRAR 1/18/54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Peninsula General Hospital ADDRESS

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1027

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury 12
LENGTH OF STAY (in this place) 1 yr. 3 mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY ~~Balto~~
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore
STREET ADDRESS (If rural give location) 1103 Myrtle Ave. ✓

3. NAME OF DECEASED: (Type or Print) (First) Edna (Middle) May (Last) GRIFFIN

4. DATE OF DEATH: (Month) 1/9 (Day) (Year) 1954

5. SEX: F

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): M

8. DATE OF BIRTH: Feb. 22, 1890

9. AGE last birthday: 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: ——

11. BIRTHPLACE (State or foreign country): Frederick, Maryland

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: Charles Stanton

14. MOTHER'S MAIDEN NAME: Eliza Summers

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) ——unk. (If Yes, give war or dates of service) ——

16. SOCIAL SECURITY NO.: ——

17. INFORMANT & ADDRESS: Hospital Records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 443X (a) Cerebral hemorrhage — Interval Between Onset And Death 24h

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Hypertensive cardiovascular disease — 3 y (?)

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Left hemiplegia & motor aphasia

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 9/22, 1952, to 1/9, 1954, that I last saw the deceased alive on 1/9, 1954, and that death occurred at 10:45 A.M., from the causes and on the date stated above.

SIGNATURE Dr. V Juerman (Degree or title) M.D. ADDRESS Deers Head State Hospital, Salisbury, Md DATE SIGNED 1/9/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan: 14, 1954 NAME OF CEMETERY OR CREMATORY Baltimore National LOCATION (City, town, or county) Baltimore, Md. (State)

DATE REC'D BY LOCAL REGISTRAR 1-12-54 REGISTRAR'S SIGNATURE A. W. Hodrick

24. FUNERAL DIRECTOR Funeral Home 1601 Druid Hill Ave. ADDRESS

JST

1067

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tyaskin
LENGTH OF STAY (in this place) Lifetime
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Tyaskin
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) George (Middle) A. (Last) Handy

4. DATE OF DEATH: (Month) Jan (Day) 4 (Year) 1954

5. SEX: M

6. COLOR OR RACE: Colored

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: May 4, 1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months 8 Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own farm

11. BIRTHPLACE (State or foreign country): White Haven

12. CITIZEN OF WHAT COUNTRY? U S

13. FATHER'S NAME: Cave Handy

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: Thomas Handy, Tyaskin, Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.0

Immediate cause (a) Acute Coronary Occlusion — Interval Between Onset And Death: 2 hours

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Arteriosclerotic Heart Disease — 5 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 23 July, 1947 to 4 Jan., 1954, that I last saw the deceased alive on 4 Jan, 1954, and that death occurred at 4 PM, from the causes and on the date stated above.

SIGNATURE (Degree or title) Richard H. Saunders M.D. ADDRESS Nanticoke Md. DATE SIGNED 1/6/53

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1/10/54 NAME OF CEMETERY OR CREMATORY Handy Cemetery LOCATION (City, town, or county) Tyaskin, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR 1/9/54 REGISTRAR'S SIGNATURE Mary W. Holloway 24. FUNERAL DIRECTOR Cornelius T. Dyer, Tyaskin, Maryland ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 4 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Gridletree Rural #1
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Emily (Middle) A. (Last) Harris

4. DATE OF DEATH: (Month) (Day) (Year) January 20-1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) Married
8. DATE OF BIRTH: Feb. 15-1884
9. AGE last birthday: 69-11-5 IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Kent England
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Willcocks
14. MOTHER'S MAIDEN NAME: Tambrowy

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: None
17. INFORMANT & ADDRESS: Mr George S. Harris, Gridletree, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Coronary Occlusion — Interval Between Onset And Death: hrs

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arterio Sclerosis - Aortic Stenosis — yrs

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Carcinoma of Breast c̄ Metastasis, general

19a. DATE OF OPERATION: 1/20/54
19b. MAJOR FINDINGS OF OPERATION: Carcinoma of Breast
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-17-, 1954, to 1-20-, 1954 that I last saw the deceased alive on 1-20-, 1954, and that death occurred at 2:55 pm, from the causes and on the date stated above.

SIGNATURE Earl L Royer (Degree or title) M.D. ADDRESS 407 Camden Ave Salisbury DATE SIGNED 1-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan. 23/54 NAME OF CEMETERY OR CREMATORY Christian LOCATION (City, town, or county) Snow Hill (State) Md

DATE REC'D BY LOCAL REGISTRAR 1-28-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Wm E. Dennis ADDRESS Snow Hill, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 26 1954
BUREAU V. S.

1029

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND — COUNTY Anne Arundel
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Annapolis
STREET ADDRESS (If rural give location) 41 Calvert Street.

3. NAME OF DECEASED: (Type or Print) (First) MARY (Middle) ELLEN (Last) HASTY
4. DATE OF DEATH: (Month) January (Day) 20th (Year) 1954
5. SEX: F.
6. COLOR OR RACE: N.
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): separated
8. DATE OF BIRTH: Sept 26th 1900
9. AGE last birthday: 53 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired).
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country). Annapolis, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: JAMES Covington.
14. MOTHER'S MAIDEN NAME: ELIZABETH SIMMS
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS:

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Generalized Ca. c aspiration pneumonia

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Oesophago-tracheal fistula

DUE TO (c) Carcinoma of oesophagus

Interval Between Onset And Death: Patient transferred from Anne Arundel Hospital Annapolis at 1/18/54.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-18, 1954, to 1/20, 1954, that I last saw the deceased alive on 1/20, 1954, and that death occurred at 3.55 AM., from the causes and on the date stated above.
SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Dr. V. Sherman M.D. Deer's Head Hospital, Salisbury 1-20-54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-24-54
NAME OF CEMETERY OR CREMATORY Brewer Hill
LOCATION (City, town, or county) (State) Annapolis, Md.
DATE REC'D BY LOCAL REGISTRAR Jan. 23, 1954
REGISTRAR'S SIGNATURE Mary H. Holloway mt
24. FUNERAL DIRECTOR ADDRESS William Reese II 108 W. Washington St. Annapolis, Md.

VS. A15

RECEIVED
JAN
BUREAU V. S.

M1033

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne
STREET ADDRESS 19X-2 (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Ernest (Middle) M (Last) Hayman

4. DATE OF DEATH: (Month) January (Day) 5 (Year) 1954

5. SEX: M

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Mar 25, 1882

9. AGE Last birthday: 71 yrs. — IF UNDER 1 YEAR Months Days — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: Merchant

10b. KIND OF BUSINESS OR INDUSTRY: Own Store

11. BIRTHPLACE (State or foreign country): Princess Anne, Md

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hayman

14. MOTHER'S MAIDEN NAME: Louisa Pusey

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No:

17. INFORMANT & ADDRESS: Lee Hayman, Princess Anne Md

18. MEDICAL CERTIFICATION

Interval Between Onset And Death

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive Heart Failure — 2 weeks

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arteriosclerotic Heart Disease

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/27, 1953, to 1/5, 1954 that I last saw the deceased alive on 1/5, 1954, and that death occurred at 1.27 PM, from the causes and on the date stated above.

SIGNATURE Fred L. Adams (Degree or title) M.D. — ADDRESS Salisbury Md. — DATE SIGNED 1/6/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/8/54 — NAME OF CEMETERY OR CREMATORY Manokin Presbyterian Cemetery — LOCATION (City, town, or county) Princess Anne (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-12-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR James Dingman — ADDRESS Princess Anne. Md

VS. A15

RECEIVED
JAN 14 1954
BUREAU V. S.

1931

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 335

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp

2. USUAL RESIDENCE (HOME) OF DECEASED.
STATE MD — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Sharptown - RURAL
STREET ADDRESS (If rural give location) Hardka, Rd

3. NAME OF DECEASED: (Type or Print) (First) William (Middle) (Last) Hepner
4. DATE OF DEATH: (Month) Jan (Day) 10 (Year) 1954
5. SEX: M
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: April 5 1887
9. AGE last birthday: 66 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Poultry
11. BIRTHPLACE (State or foreign country): Md
12. CITIZEN OF WHAT COUNTRY? U.S.
13. FATHER'S NAME: William Hepner
14. MOTHER'S MAIDEN NAME: Rena Metz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Yes (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 224-07-1937
17. INFORMANT & ADDRESS: Mrs William Hepner

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause (a) Acute Coronary Artery Occlusion — Interval Between Onset And Death: Minutes 24 hr.
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b)
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 9, 1954 to Jan. 10, 1954 that I last saw the deceased alive on Jan. 10, 1954 and that death occurred at 7:20 A.M., from the causes and on the date stated above.
SIGNATURE (Degree or title) David L. Fillmore M.D. — ADDRESS Salisbury Md. — DATE SIGNED Jan. 11, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF 1/13/54 — NAME OF CEMETERY OR CREMATORY Friendship Cemetery — LOCATION (City, town, or county) (State) Sharptown Md
DATE REC'D BY LOCAL REGISTRAR 1/13/54 — REGISTRAR'S SIGNATURE Mary C. Owens
24. FUNERAL DIRECTOR Paul G. Smith — ADDRESS Sharptown Md

VS. A15

RECEIVED
JAN 18 1954
BUREAU V. S.

1032

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Larmore

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Melsons
STREET ADDRESS (If rural give location) R. D. # 3 (Salisbury)

**3. NAME OF DECEASED:** (Type or Print) (First) Hyland (Middle) WASHINGTON (Last) Hill

**4. DATE OF DEATH** (Month) January (Day) 26 (Year) 1954

**5. SEX:** male

**6. COLOR OR RACE:** white

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Married

**8. DATE OF BIRTH:** Aug 18, 1889

**9. AGE** Last Birthday: 64 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Farmer

**10b. KIND OF BUSINESS OR INDUSTRY:** On Own Farm

**11. BIRTHPLACE** (State or foreign country): Snow Hill Maryland.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** George Hill

**14. MOTHER'S MAIDEN NAME:** Mary Martin

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mrs. Lula Ethel Hill (Wife) R.D. # 3 Sal. Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause — (a) Coronary thrombosis, myocardial infarct — DUE TO — Interval Between Onset And Death: 1 day.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. — (b) — DUE TO

(c) Coronary arteriosclerosis — ?

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death. arthritis bronchitis — 2 years

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☒

**21.** ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐ (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/3 ,1950, to 1/26/ , 1954, that I last saw the deceased alive on 1/25, 1954, and that death occurred at 9:18 a.m., from the causes and on the date stated above.

SIGNATURE Ernest M. Larmore (Degree or title) M.D. ADDRESS Delmar, Del DATE SIGNED 1/26/54

**23. BURIAL, CREMATION, REMOVAL** (Specify) Burial — DATE THEREOF Jan 29, 1954 — NAME OF CEMETERY OR CREMATORY Melsons Cemetery — LOCATION (City, town, or county) (State) Near Delmar Md. & Parsonsburg

DATE REC'D BY LOCAL REGISTRAR 1-27-54 — REGISTRAR'S SIGNATURE Mary M. Holloway

**24. FUNERAL DIRECTOR** HOLLOWAY & COMPANY SALISBURY — ADDRESS MARYLAND

Walter R. Holloway

Walter R. Holloway

RECEIVED
JAN 29 1934
BUREAU V. S.

1008

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr Lewis Willards Md

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Pittsville
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS XXXXXX At Home X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pittsville X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) EMMA (Middle) CAROLINE (Last) HOLLOWAY
4. DATE OF DEATH: (Month) JAN (Day) 20 (Year) 19 54

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed
8. DATE OF BIRTH: Sept. 6, 1877
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR Months 4 Days 14 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): House Wife
10b. KIND OF BUSINESS OR INDUSTRY: House Work at Home
11. BIRTHPLACE (State or foreign country): R.D. Parsonsburg, Md.
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Martin Hancock
14. MOTHER'S MAIDEN NAME: Laura White

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) 4 No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mr. Horace Holloway Ocean City Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

170 X

Immediate cause (a) metastatic carcinoma right breast — Interval Between Onset And Death 2 years.

DUE TO (adeno carcinoma)

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Hypertension - chronic myocarditis.

19a. DATE OF OPERATION: breast removed 1 year ago
19b. MAJOR FINDINGS OF OPERATION adeno carcinoma rt. breast
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1940, 19..., to day of death, that I last saw the deceased alive on 1-20, 1954, and that death occurred at 8 a.m., from the causes and on the date stated above.

SIGNATURE Frank Lewis M.D. (Degree or title) ADDRESS Willards Md. DATE SIGNED 1-21-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 22, 1954
NAME OF CEMETERY OR CREMATORY Forest Grove Cemetery
LOCATION (City, town, or county) (State) Near Parsonsburg, Maryland

DATE REC'D BY LOCAL REGISTRAR 1-21-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY ADDRESS MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
BUREAU V. S.

1033

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 1
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Princess Anne
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) (Last) Holloway

4. DATE OF DEATH: (Month) January (Day) 9 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

8. DATE OF BIRTH: Aug 9, 1886

9. AGE last birthday: 67 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Baltimore, Md

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: John Fitzelberger

14. MOTHER'S MAIDEN NAME: Martha Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mr. Fred E. Benson, Princess Anne Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Thrombosis — Interval Between Onset And Death: 1 wk

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-3, 1954, to 1-9, 1954, that I last saw the deceased alive on 1-9, 1954, and that death occurred at 2.50 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or Title) Lee L Lawry, M D. ADDRESS Fruitland, Md DATE SIGNED 1-19-54

23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF 1-10-53 | NAME OF CEMETERY OR CREMATORY Episcopal Cemetery | LOCATION (City, town, or county) (State) Princess Anne Md

DATE REC'D BY LOCAL REGISTRAR 1-21-54 | REGISTRAR'S SIGNATURE Mary M. Holloway | 24. FUNERAL DIRECTOR James Kinman | ADDRESS Princess Anne Md.

VS. A15

RECEIVED
JAN
BUREAU V. S

1034

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 532

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Worcester — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 22 Days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Newark Rural #1
STREET ADDRESS (If rural give location)

| 3. NAME OF DECEASED: (First) (Middle) (Last) (Type or Print) | 4. DATE OF DEATH: (Month) (Day) (Year) |
|---|---|
| Mary P. Holston | January 25 1954 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Single | Feb. 19 1894 | 59-11-6 years | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| Housewife | Own Home | Snow Hill Md | |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Irving B. Holston | Charlotte E. Cottingham |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | None | Mrs Myrtle M. Holston, Newark Md Rural #1 |

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Pulmonary infarct

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma of Colon c metastases — 6 months

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| / | Carcinoma Colon c diverticulosis Fistula | Yes ☐ No ☑ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from ..... ....., 19..... , to ..... ..... , 19.. , that I last saw the deceased alive on Jan 25, 1954, and that death occurred at 5:50 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) William C. Tilson Jr. ADDRESS 226 N Division St Salisbury DATE SIGNED 1-25-54

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) | (State) |
|---|---|---|---|---|
| Burial | Jan 27/54 | Bivey | Newark | Md |

| DATE REC'D BY LOCAL REGISTRAR | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-27-54 | Mary M. Holloway | Elmer C. Dennis | Snow Hill Md |

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MARYLAND

STATE DEPARTMETT OF HEALTH

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

| | |
|---|---|
| 1. PLACE OF DEATH COUNTY Wicomico MARYLAND | 2. USUAL RESIDENCE (HOME) OF DECEASED STATE Maryland COUNTY Wicomico |
| CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela Springs - Rural; LENGTH OF STAY (in this place) Life | CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardela Springs - Rural |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS Mardela-Salisbury Road X | STREET ADDRESS (If rural, give location) Mardela-Salisbury Road |

| | | | | | |
|---|---|---|---|---|---|
| 3. NAME OF DECEASED (Type or Print) | (First) Addie | (Middle) Mae | (Last) Horsey | 4. DATE OF DEATH | (Month) January (Day) 28 (Year) 54 |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed | 8. DATE OF BIRTH August 12, 1880 | 9. AGE last birthday 73 yrs. | If under 1 year Months, Days; If under 24 hrs. Hours, Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | 10b. KIND OF BUSINESS OR INDUSTRY Home | | 11. BIRTHPLACE (State or foreign country) Wicomico County, Maryland | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME James D. Jefferson | | | 14. MOTHER'S MAIDEN NAME Mary E. Hull | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If year, give war or dates of service) | 16. SOCIAL SECURITY NO. None | | 17. INFORMANT AND ADDRESS Annie H. Waller, Mardela Springs, Md. | | |

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

490 X

Immediate cause (a) Lobar Pneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 weeks

Antecedent cause(s) (b) Pneumoccic Meningitis — 10 days

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☐ |
| 21. ACCIDENT SUICIDE HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) (COUNTY) (STATE) |
| TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at Work ☐ Not While At work ☐ | HOW DID INJURY OCCUR? |

22. I hereby certify that I attended the deceased from 1/15, 1954, to 1/28/54 19.., that I last saw the deceased alive on 1/28/54 19.., and that death occurred at 2 p. m., from the causes and on the date stated above.

SIGNATURE H. S. Kuhlman - MD (Degree or title) ADDRESS Sharptown Md DATE SIGNED 1/30/54

| | | | |
|---|---|---|---|
| 23. BURIAL, CREMATION REMOVAL (Specify) Burial | DATE Jan. 31, 1954 | NAME OF CEMETERY OR CREMATORY Mardela Cemetery | LOCATION (City, town, or county) (State) Mardela Springs, Md. |
| DATE REC'D BY LOCAL REG. 2-5-54 | REGISTRAR'S SIGNATURE Mary W. Holloway | 24. FUNERAL DIRECTOR J.J. Framptom and Son, Federalsburg, Md. | ADDRESS |

MARGIN RESERVED FOR BINDING

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Deershead Salisbury
LENGTH OF STAY (in this place) 18 months
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deershead Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Bivalve
STREET ADDRESS (If rural, give location)

3. NAME OF DECEASED: (Type or Print) (First) EDNA (Middle) Ann (Last) HORSMAN
4. DATE OF DEATH: (Month) Jan. (Day) 19 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widow
8. DATE OF BIRTH: July 29, 1869
9. AGE last birthday: 84 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Sam Larmore
14. MOTHER'S MAIDEN NAME: Mary Ellen Adams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Edward Horsman, Bivalve, Md.

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause 420.0 | (a) | Arteriosel. heart disease | 10 (?) |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) | Arteriosel. generalized | ? |
| | DUE TO (c) | | |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Parkinson's Syndrome 8 (?)

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION:
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/15, 1952 to 1/19, 1954, that I last saw the deceased alive on 1/18, 1954, and that death occurred at 3:30 p.m., from the causes and on the date stated above.

SIGNATURE D. V. Maldre, M.D. (DEGREE OR TITLE) Deershead ADDRESS State Hosp. Salisbury Md. DATE SIGNED 1/19/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 1/21/54
NAME OF CEMETERY OR CREMATORY Bivalve Cemetery
LOCATION (City, town, or county) (State) Bivalve, Maryland

DATE REC'D BY LOCAL REG. 1-20-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR [illegible] Bivalve, ADDRESS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

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RECEIVED
JAN
BUREAU V. S.

1028

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND; CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Salisbury; LENGTH OF STAY (in this place); HOSPITAL OR INSTITUTION OR STREET ADDRESS Enroute to hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Florida COUNTY St. Lucie; CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Fort Pierce; STREET ADDRESS (If rural, give location) None

3. NAME OF DECEASED: (Type or Print) (First) Betty (Middle) LEE (Last) Huling

4. DATE OF DEATH (Month) Jan. (Day) 22 (Year) 1954

5. SEX: F

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: June 1, 1928

9. AGE Last birthday: 25 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At Own Home

11. BIRTHPLACE (State or foreign country): Wicomico Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Clyde Charles Darby

14. MOTHER'S MAIDEN NAME: Abby Marshall Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Roy Huling (Husband) Fort Pierce Florida

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Fractured skull and brain injury — DUE TO — Interval Between Onset and Death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY Highway

21c. (City or town) Salisbury (County) Wicomico (State) Maryland

21d. TIME OF INJURY (Month) (Day) (Year) (Hour) Jan. 22, 54 3A. M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☒ 1

21f. HOW DID INJURY OCCUR? Auto and truck collision

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE [signature] M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 1/23/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF Jan. 27, 1954

NAME OF CEMETERY OR CREMATORY New Hope Cemetery

LOCATION (City, town, or county) (State) Near Willards Maryland

DATE REC'D BY LOCAL REG. 1-27-54

REGISTRAR'S SIGNATURE Mary M. Holloway Walter R. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND

VS. A15A - 5 - 53

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN Rockawalkin X
LENGTH OF STAY (in this place) 22 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rockawalkin X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rockawalkin X
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Alpheus (Middle) Jay (Last) Humphreys

4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married

8. DATE OF BIRTH: Apr. 2, 1879

9. AGE last birthday: 74 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Own Farm

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: Alpheus Humphreys

14. MOTHER'S MAIDEN NAME: Augusta Evans

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16 SOCIAL SECURITY No.: None

17. INFORMANT & ADDRESS: Franklin Humphreys Same

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Cerebral Hemorrhage DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO (c)

Interval Between Onset And Death: 4 yrs

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Arteriosclerotic heart disease 4 yrs

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/22/54 to 1/25/54, that I last saw the deceased alive on 1/25/54, and that death occurred at 4:30 PM from the causes and on the date stated above.

SIGNATURE Thurman R Mann (Degree or title) MD ADDRESS Salisbury Md DATE SIGNED 1/26/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1/28/54 NAME OF CEMETERY OR CREMATORY Parsons Cemetery LOCATION (City, town, or county) Salisbury, (State) Maryland

DATE REC'D BY LOCAL REGISTRAR 1-27-54 REGISTRAR'S SIGNATURE Mary M Holloway

24. FUNERAL DIRECTOR AND ADDRESS The Hill & Johnson Co. Salisbury George C Hill II

VS. A15

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BUREAU V. S.

1937

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 1103 E. Church St.

3. NAME OF DECEASED (Type or Print) (First) ~~Mattie~~ (Middle) Madeline (Last) Humphreys
4. DATE OF DEATH: (Month) January (Day) 31 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Oct 29 1888
9. AGE last birthday: 65 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William T. Layfield
14. MOTHER'S MAIDEN NAME: Mary Hughes

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: no
17. INFORMANT & ADDRESS: Mr Fillmore Dryden Salisbury Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Thrombosis DUE TO

Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Hypertension & Arteriosclerosis DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/20/54 19..., to 1-31, 1954 that I last saw the deceased alive on 1/31/54 19..., and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE C. L. Hearn (Degree or title) M.D. ADDRESS 113 W Church St DATE SIGNED 1/31/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 2-1-54 NAME OF CEMETERY OR CREMATORY Parson Cemetery LOCATION (City, town, or county) Salisbury, Md (State)

DATE REC'D BY LOCAL REGISTRAR 2-2-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Lewis R. Wilson ADDRESS Princess Anne, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
FEB 4
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 1018

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
RURAL 12
MARYLAND LENGTH OF STAY (in this place) 2 days
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula Gen. Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 323 Elmwood St.

3. NAME OF DECEASED: (First) EMMA (Middle) LUCRETIA (Last) JOHNSON
4. DATE OF DEATH: (Month) 1 (Day) 18 (Year) 1954
5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):
8. DATE OF BIRTH: Apr. 9, 1872
9. AGE last birthday: 81 yrs.
IF UNDER 1 YEAR Months 9 Days
IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Home wife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joshua Morris
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) No
(If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT & ADDRESS: Morris Johnson - Same

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause 420.0
(a) Coronary Occlusion
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Arteriosclerotic Heart Disease
DUE TO
(c)
Interval Between Onset And Death: Sudden

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
(CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/14 ..., 1953, to 1/18 ..., 1954, that I last saw the deceased alive on 1/18/54, 19..., and that death occurred at 8:10 pm, from the causes and on the date stated above.
SIGNATURE (Degree or title) ADD[illegible] DATE SIGNED
Fred D. Graves M.D. Salisbury Md. 1/19/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1/21/54
NAME OF CEMETERY OR CREMATORY Parsons Cemetery
LOCATION (City, town, or county) Salisbury (State) Md.
DATE REC'D BY LOCAL REGISTRAR 1/19/54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR The Hill & Johnson Co.
George C. Hill
ADDRESS

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
JAN 21 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) all life
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural, give location) 218 Lake Street

3. NAME OF DECEASED: (Type or Print) (First) WILLIAM (Middle) THOMAS (Last) JOHNSON

4. DATE OF DEATH (Month) Jan. (Day) 24 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: A.A.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single

8. DATE OF BIRTH: 1/28/1900

9. AGE last birthday: 53 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Janitor

11. BIRTHPLACE (State or foreign country): Salisbury, Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Slemons Johnson

14. MOTHER'S MAIDEN NAME: Lula Horsey

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No

16. SOCIAL SECURITY NO.: --

17. INFORMANT & ADDRESS: Mrs. Lillian Jones; 222 Catherine St. Salisbury, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause (a) Coronary Thrombosis DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b) DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH Sudden death

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

19a. DATE OF OPERATION:

19b. MAJOR FINDING OF OPERATION:

20. AUTOPSY? Yes ☑ No ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY

21c. (City or town) (County) (State)

21d. TIME (Month) (Day) (Year) (Hour) OF INJURY M.

21e. INJURY OCCURRED While at work ☐ Not while at work ☐

21f. HOW DID INJURY OCCUR?

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE H. Kaduncz M. D.

CHIEF MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ASSISTANT MEDICAL EXAM. ☐

DATE SIGNED 1/26/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial

DATE THEREOF 1/27/54

NAME OF CEMETERY OR CREMATORY Houston Cemetery

LOCATION (City, town, or county) (State) Salisbury-Wicomico-Maryland

DATE REC'D BY LOCAL REG. 1-27-54

REGISTRAR'S SIGNATURE Mary M. Holloway

24. FUNERAL DIRECTOR Mary A. Stewart

ADDRESS 324 Church St. Salisbury, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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BUREAU V. S

1071

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Willards X
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS in village X

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Md. Wicomico COUNTY
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Willards
STREET ADDRESS (If rural give location) in village

3. NAME OF DECEASED: (Type or Print) (First) John (Middle) Thomas (Last) Jones
4. DATE OF DEATH: (Month) Jan (Day) 10 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Married
8. DATE OF BIRTH: May 6-1877
9. AGE last birthday: 76 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Own Farm
11. BIRTHPLACE (State or foreign country): Worcester Co. Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Thomas Asbury Jones
14. MOTHER'S MAIDEN NAME: Mary Elizabeth Williams

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Mrs Myra P. Jones (Wife) Willards Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
153X
Immediate cause (a) Carcinoma ascending colon (diag. made by recent gen. ...)
DUE TO
Antecedent causes(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b)
DUE TO
(c)

Interval Between Onset And Death: 2 yrs.

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. arteriosclerosis - arthritis

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) —
(CITY OR TOWN) Willards (COUNTY) Wicomico (STATE) Maryland
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR? —

22. I hereby certify that I attended the deceased from 1951, 19 , to day of death, that I last saw the deceased alive on 1-10, 1954, and that death occurred at 5:50 P, from the causes and on the date stated above.
SIGNATURE (Degree or title) Frank Lewis M.D.
ADDRESS Willards Maryland
DATE SIGNED 1-11-54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF Jan. 13-54
NAME OF CEMETERY OR CREMATORY Mt. Pleasant Cem.
LOCATION (City, town, or county) Near Nutwell Md. (State)
DATE REC'D BY LOCAL REGISTRAR 1-12-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Holloway & Co. Salisbury Md.
ADDRESS Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 14 1954
BUREAU V. S.

Film G160 Item# 3,7 1/22/54 emf

1040

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 352

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Wicomico — STATE: MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
LENGTH OF STAY (in this place): 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fruitland
STREET ADDRESS (If rural give location): Main Street

**3. NAME OF DECEASED (Type or Print):** (First) JOHN (Middle) WESLEY William (Last) JONES

**4. DATE OF DEATH:** (Month) JAN (Day) 14 (Year) 19 54

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):** divorced

**8. DATE OF BIRTH:** Aug. 28, 1880

**9. AGE last birthday:** 73 yrs. — IF UNDER 1 YEAR: Months 4, Days 16 — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired): Retired Laborer

**10b. KIND OF BUSINESS OR INDUSTRY:** Laborer

**11. BIRTHPLACE** (State or foreign country): Eden, Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Edward Wesley Jones

**14. MOTHER'S MAIDEN NAME:** Indiana Hopkins

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mrs. Ethel Jones R.D. #2 Eden, Maryland

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

420.1

Immediate cause (a) Myocardial Infarct, acute — Interval Between Onset And Death: 8 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) arteriosclerotic coronary thrombosis (1)
DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☒ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

**PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m.

**INJURY OCCURED** While at Work ☐ Not While At Work ☐

**HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from I — 13 54 to I — 14 54, that I last saw the deceased alive on I — 14, 19 54, and that death occurred at 2 P.M., from the causes and on the date stated above.

SIGNATURE: Wilbur R. Ellis (Degree or title) M.D. ADDRESS: Camden Avenue Salisbury, Maryland DATE SIGNED: Jan. 16 1954

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial
DATE THEREOF: Jan. 17, 1954
NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park
LOCATION (City, town, or county) (State): Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-16-54
REGISTRAR'S SIGNATURE: Mary W. Holloway

**24. FUNERAL DIRECTOR** ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway — Walter R. Holloway

RECEIVED
JAN 19 1934
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Royer

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Salisbury 12
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Parsonsburg
STREET ADDRESS (If rural give location) R. D. # 2

3. NAME OF DECEASED: (Type or Print) (First) VERA (Middle) MABEL (Last) KIMM

4. DATE OF DEATH: (Month) January (Day) 12 (Year) 1954

5. SEX: Female

6. COLOR OR RACE? White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married

8. DATE OF BIRTH: March 31, 1895

9. AGE last birthday: 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: House Work at Home

11. BIRTHPLACE (State or foreign country): Pittsburg Pa.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Walters

14. MOTHER'S MAIDEN NAME: Vera (No Record)

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mr. Sargen Kimm (Husband) R.D. # 2 Parsonsburg Maryland

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Occlusion — Interval Between Onset And Death 5 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Arterio-Sclerotic C.V. Disease — yrs.

DUE TO (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Aortic Stenosis

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 20 Dec., 1953, to 1-12-1954 that I last saw the deceased alive on 1/12 1954, and that death occurred at 8 Am. from the causes and on the date stated above.

SIGNATURE Emil Royer (Degree or Title) M.D. ADDRESS 407 Camden Ave DATE SIGNED 1/12/54

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF Jan. 15, 1954 NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REGISTRAR 1-13-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR HOLLOWAY & COMPANY SALISBURY ADDRESS MARYLAND

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 15 1934
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
MARYLAND
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY W
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Rout 2 Box 208
STREET ADDRESS (If rural give location) Pocomoke City

3. NAME OF DECEASED: (Type or Print) (First) Larry (Middle) E. (Last) Knot

4. DATE OF DEATH: (Month) January (Day) 16 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: C

7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): Single

8. DATE OF BIRTH: May 12, 1951

9. AGE last Birthday: 2 yrs.
IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Levi Knot

14. MOTHER'S MAIDEN NAME: Odessa Buckingham

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No
(If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Odessa Knot Pocomoke City

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Bronchial Obstruction — Interval Between Onset And Death: 2 wks.

Antecedent causes (s) Diseases or conditions, If any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Myelogenous Leukemia — 2 mo.
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-21 ..., 19 53, to 1-16 ..., 1954, that I last saw the deceased alive on 1-16 ..., 1954, and that death occurred at 7:05 Am, from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Warren A. Lambdin MD. Salisbury Md. 1-16-54

23. BURIAL, CREMATION, REMOVAL (Specify) Buried
DATE THEREOF 1/18/54
NAME OF CEMETERY OR CREMATORY St. Peters-em
LOCATION (City, town, or county) (State) Pocomoke City Md.

DATE RECD BY LOCAL REGISTRAR 1-16-54
REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Edgar Richardson
ADDRESS New church Va.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 19 1904
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. William Smith

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Wicomico — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): Pemberton (R.D. # 5) Drive

**3. NAME OF DECEASED:** (Type or Print) (First) MARCELENE (Middle) SUSAN (Last) LAMANQUE

**4. DATE OF DEATH:** (Month) JAN (Day) 7 (Year) 19 54

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Child

**8. DATE OF BIRTH:** Nov. 13, 1952

**9. AGE last birthday:** 1 yrs. — IF UNDER 1 YEAR: Months 1, Days 24 — IF UNDER 24 HRS.: Hours, Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): None

**10b. KIND OF BUSINESS OR INDUSTRY:** None

**11. BIRTHPLACE** (State or foreign country): Salisbury, Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Henry J. Lamanque

**14. MOTHER'S MAIDEN NAME:** Ethel Florence Donawey

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mr. Hemry Lamangue (Father) Pemberton Drive

**18. MEDICAL CERTIFICATION** R.D. #5 Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

057.0

Immediate cause (a) DUE TO: Spinal Meningitis

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) DUE TO: Meningococcus

(c)

**11. OTHER SIGNIFICANT CONDITIONS** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** — **19b. MAJOR FINDINGS OF OPERATION** — **20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

**TIME OF INJURY** (Month) (Day) (Year) (Hour) m. — **INJURY OCCURED** While at Work ☐ Not While At Work ☐ — **HOW DID INJURY OCCUR?**

22. I hereby certify that I attended the deceased from 1-6, 1954, to 1-7, 1954, that I last saw the deceased alive on 1-6, 1954, and that death occurred at 6:10 A.M., from the causes and on the date stated above.

SIGNATURE: Wm. Smith — (Degree or title) M.D — ADDRESS: 222 North Division Street. Salisbury, Md. — DATE SIGNED: Jan. 8 1954

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — **DATE THEREOF:** Jan. 9, 1954 — **NAME OF CEMETERY OR CREMATORY:** Wicomico Memorial Park — **LOCATION** (City, town, or county) (State): Salisbury, Maryland

**DATE REC'D BY LOCAL REGISTRAR:** 1-8-54 — **REGISTRAR'S SIGNATURE:** Mary W. Holloway

**24. FUNERAL DIRECTOR:** HOLLOWAY & COMPANY — **ADDRESS:** SALISBURY MARYLAND

Walter R. Holloway

Walter R. Holloway

1 11 1954

BUREAU V. S.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 1 yr.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Riverside Convelesist Home

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Princess Anne Md.
STREET ADDRESS (If rural give location) Mt Vernon, Rd.

3. NAME OF DECEASED: (Type or Print) (First) Aneidona (Middle) (Last) Mason

4. DATE OF DEATH: (Month) 1 (Day) 25 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed.
8. DATE OF BIRTH: Feb 5, 1862
9. AGE last birthday: 91 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Edgar Dashiell
14. MOTHER'S MAIDEN NAME: Elizabeth Dashiell

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: Steve Mason Mt. Vernon, Md

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 4201
(a) Coronary Artery Occlusion — Interval Between Onset And Death: 2 hours
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) Coronary Atherosclerosis — Symptoms 1 yr.
DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Cerebral Atherosclerosis — Symptoms 1 yr

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 1953 to Jan. 25, 1954, that I last saw the deceased alive on Jan 25, 1954 and that death occurred at 3:30 AM, from the causes and on the date stated above.

SIGNATURE David J. Gilmore (Degree or title) M.D. ADDRESS Salisbury Md. DATE SIGNED Jan 26, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) burial
DATE THEREOF 1/27/54
NAME OF CEMETERY OR CREMATORY Asbury Cemetery
LOCATION (City, town, or county) Mt Vernon (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-26-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR James Hinman, ADDRESS Princess Anne Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 1954
BUREAU V. S.

1954 M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (In this place) 6 WKS.
HOSPITAL OR INSTITUTION OR STREET ADDRESS 311 W. HAZEL AVE

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE MARYLAND WICOMICO
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
STREET ADDRESS (If rural give location) 311 W. HAZEL AVE.

3. NAME OF DECEASED: (Type or Print) (First) IRA (Middle) BLISS (Last) MEZICK

4. DATE OF DEATH: (Month) 1 (Day) 2 (Year) 1954

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): SINGLE

8. DATE OF BIRTH: MAY 1880

9. AGE last birthday: 73 yrs. IF UNDER 1 YEAR Months Days; IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: ANTIQUE DEALER

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY: U.S.A.

13. FATHER'S NAME: JOHN C. D. MEZICK

14. MOTHER'S MAIDEN NAME: ESTHER DAVIS

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT & ADDRESS: MRS GLADYS CHATHAM – SAME

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

196X

Immediate cause (a) Carcinoma, left mastoid

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death: 18 months

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: Oct. 20, 1953

19b. MAJOR FINDINGS OF OPERATION: Left mastoid filled with carcinoma.

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from June 2, 1953, to Dec. 30, 1953, that I last saw the deceased alive on Dec. 30, 1953, and that death occurred at 1:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) J. Brewington Jr. M.D. ADDRESS Salisbury, Md. DATE SIGNED Jan. 4, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL DATE THEREOF 1/4/54 NAME OF CEMETERY OR CREMATORY MEZICK CEMETERY LOCATION (City, town, or county) CLARA, (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-4-54 REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Hill & Johnson Co. ADDRESS Salisbury, Md.
George C. Hill II

VS. A15

N C 1954
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 232

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL) OR TOWN and give nearest town): Salisbury
LENGTH OF STAY (in this place): 2yr. 3mo.
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Md. — COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Baltimore, 2
STREET ADDRESS (If rural give location): 126 Market Place

3. NAME OF DECEASED: (First) MOSE (Middle) (Last) MiLLer

4. DATE OF DEATH: (Month) January (Day) 21st (Year) 1954

5. SEX: M.

6. COLOR OR RACE: N

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: ?

9. AGE last birthday: 72 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): N. Carolina

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: BEN MILLER

14. MOTHER'S MAIDEN NAME: MOLLIE ?

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unknown — (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Hospital records.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause: 332.X (a) Cerebral thrombosis — Interval Between Onset And Death: 35 min.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

DUE TO (b) Severe general arteriosclerosis — 10 years

DUE TO (c) 028.2

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Latent syphilis — ?

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-1 ,1952, to 1-21 , 1954, that I last saw the deceased alive on 1-21 , 1954, and that death occurred at 11 55 p.m., from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED

Dr Guerman M.D. Deer's Head Hospital, Salisbury 1-22-54

23. BURIAL, CREMATION, REMOVAL (Specify): Removal — DATE THEREOF: 1-25-54 — NAME OF CEMETERY OR CREMATORY: Centennial Bd. — LOCATION (City, town, or county) (State): Balto city

DATE REC'D BY LOCAL REGISTRAR: 1-25-54 — REGISTRAR'S SIGNATURE: Mary W. Hoover

24. FUNERAL DIRECTOR — ADDRESS: Booker M West.

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place) 7 Mo
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital Salisbury Md

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY
STREET ADDRESS (If rural give location) 612 Westover Circle.

3. NAME OF DECEASED: (Type or Print) (First) Ruth (Middle) Corbin (Last) Mills

4. DATE OF DEATH: (Month) January (Day) 4, (Year) 1954

5. SEX: F.

6. COLOR OR RACE: Negro

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): widowed

8. DATE OF BIRTH: Oct. 2nd 1909

9. AGE last birthday: 44 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired): —

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): Atlantic (Va)

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: HORACE Bailey

14. MOTHER'S MAIDEN NAME: Florence Ann Tull

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) Unk.

16. SOCIAL SECURITY NO.: —

17. INFORMANT & ADDRESS: HOSPITAL RECORDS

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

174 X

Immediate cause (a) Cerebral Embolus due to Ca — Interval Between Onset And Death: 3 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Carcinoma uteri c̄ metastases inoperable — 2 years

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 5/22, 1953, to 1/4, 1954, that I last saw the deceased alive on 1/4, 1954, and that death occurred at 5:25 AM EST from the causes and on the date stated above.

SIGNATURE (Degree or title) Dr. V Jenerman M.D. ADDRESS Deer's Head Hospital, Salisbury DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify) Burial

DATE THEREOF 1-10-54

NAME OF CEMETERY OR CREMATORY Wattsville Cem

LOCATION (City, town, or county) Wattsville Ac. (State) Va

DATE REC'D BY LOCAL REGISTRAR 1-8-54

REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR Booker Holbert ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Mitchell

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Pen. Gen. Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): 1001 Cecil St.

3. NAME OF DECEASED: (Type or Print) (First) MYRTLE (Middle) VIRGINIA (Last) MORGAN

4. DATE OF DEATH: (Month) JAN (Day) 19 (Year) 1954

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widowed

8. DATE OF BIRTH: June 10, 1891

9. AGE last birthday: 62 yrs. IF UNDER 1 YEAR: Months 7 Days 9 IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: House Wife

10b. KIND OF BUSINESS OR INDUSTRY: At own Home

11. BIRTHPLACE (State or foreign country): Wesson Miss.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: William Wallace

14. MOTHER'S MAIDEN NAME: Mary Frances ----------

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Christine Larmore 1001 Cecil St.

18. MEDICAL CERTIFICATION — Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Congestive heart failure — Interval Between Onset And Death

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Cerebro - Vascular accident

DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify) PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. INJURY OCCURED While at Work ☐ Not While At Work ☐ HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 10/9 ..., 19 53, to 1/19 ..., 19 54, that I last saw the deceased alive on 1/19 ..., 19 54, and that death occurred at 3:10 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): R. C. Mitchell, M.D. ADDRESS: North Division St. Salisbury, Maryland DATE SIGNED: Jan. 21 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 21, 1954 — NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — LOCATION (City, town, or county) (State): Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-21-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY SALISBURY MARYLAND — ADDRESS

Walter R. Holloway

VS. A15

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury 1
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS (If rural give location) 800 West Road

3. NAME OF DECEASED: (Type or Print) (First) Sherman (Middle) (Last) Nicholson

4. DATE OF DEATH: (Month) (Day) (Year) January 14 1954

5. SEX: Male
6. COLOR OR RACE: colored
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Single
8. DATE OF BIRTH: Aug 23 1930
9. AGE last birthday: 23 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY: Labor
11. BIRTHPLACE (State or foreign country): North Carolina
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Sherman Nickalson
14. MOTHER'S MAIDEN NAME: Leola Martin

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.: ?
17. INFORMANT & ADDRESS: Leola Nickalson Salisbury Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

416X

Immediate cause (a) Myocardial Insufficiency — Interval Between Onset And Death 2 yrs

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Rheumatic Heart Disease — Unknown

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☒ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Jan. 13, 1954, to Jan 14, 1954 that I last saw the deceased alive on Jan 14, 1954, and that death occurred at 2:45 P.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D. ADDRESS Salisbury Md. DATE SIGNED Jan 15, 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 1-18-1953
NAME OF CEMETERY OR CREMATORY Rockingham Cemetery
LOCATION (City, town, or county) (State) Rockingham N.C.

DATE REC'D BY LOCAL REGISTRAR 1-16-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Levin R. Wilson ADDRESS Princess Anne, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: Wicomico — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
LENGTH OF STAY (in this place): 1 year
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Deer's Head State Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: St. Mary's
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Park Hall
STREET ADDRESS (If rural give location): --

**3. NAME OF DECEASED (Type or Print):** (First) Charles (Middle) Albert (Last) Page

**4. DATE OF DEATH:** (Month) 1 (Day) 25 (Year) 1954

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** Single

**8. DATE OF BIRTH:** Aug. 3, 1891

**9. AGE last birthday:** 62 yrs.
IF UNDER 1 YEAR: Months | Days — IF UNDER 24 HRS.: Hours | Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired): Unknown

**10b. KIND OF BUSINESS OR INDUSTRY:** --

**11. BIRTHPLACE** (State or foreign country): Shreveport, La.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** Charles F. Page

**14. MOTHER'S MAIDEN NAME:** Henderson

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.): Unknown — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:** ---

**17. INFORMANT & ADDRESS:** Hospital Records

**18. MEDICAL CERTIFICATION**

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Pulmonary Edema, acute — Interval Between Onset And Death: 48 hrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) arteriosclerotic Heart disease — ?
DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Multiple sclerosis — ?

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1-15 ..., 1953, to 1-25 , 1954, that I last saw the deceased alive on 1-25 , 1954, and that death occurred at 10:50 A.M. from the causes and on the date stated above.

SIGNATURE: Robert Stone (Degree or title): MD — ADDRESS: Deershead St Hosp. — DATE SIGNED: 1-25-54

**23. BURIAL, CREMATION, REMOVAL** (Specify): Burial — DATE THEREOF: Jan. 29, 1954 — NAME OF CEMETERY OR CREMATORY: Wicomico Memorial Park — LOCATION (City, town, or county) (State): Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR: 2/1/54 — REGISTRAR'S SIGNATURE: Mary Holloway — **24. FUNERAL DIRECTOR** ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

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Gray

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

1. PLACE OF DEATH:
COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
MARYLAND LENGTH OF STAY (In this place) 10 yrs.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Rt. #4

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Wicomico (County)
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
STREET ADDRESS Rt #4 (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) WALTER (Middle) THOMAS (Last) PARKER

4. DATE OF DEATH: (Month) 1 (Day) 28 (Year) 1954

5. SEX: MALE
6. COLOR OR RACE: WHITE
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED
8. DATE OF BIRTH: JUNE 16, 1884
9. AGE last birthday: 69 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: MECHANIC
10b. KIND OF BUSINESS OR INDUSTRY: AUTO
11. BIRTHPLACE (State or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN W. PARKER
14. MOTHER'S MAIDEN NAME: JULIA LEONARD

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) NO (If Yes, give war or dates of service)
16. SOCIAL SECURITY No.: 220-12-0058
17. INFORMANT & ADDRESS: ROXIE P. PARKER - SAME

18. MEDICAL CERTIFICATION

1 DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH
Immediate cause: 201X
(a) DUE TO: Hodgkins Disease
Interval Between Onset And Death: 5 mos.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b) DUE TO
(c)

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: /
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept. 1953, to Jan 28, 1954, that I last saw the deceased alive on Jan 27, 1954, and that death occurred at 2.33 p.m., from the causes and on the date stated above.
SIGNATURE (Degree or title) William D Gray MD
ADDRESS Salisbury Md
DATE SIGNED 1/29/54

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 1/30/54
NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY
LOCATION (City, town, or county) SALISBURY, MD. (State)
DATE REC'D BY LOCAL REGISTRAR 1-29-54
REGISTRAR'S SIGNATURE Mary W Holloway
24. FUNERAL DIRECTOR THE HILL & JOHNSON CO.
ADDRESS Salisbury
Franklin B. Hill Jr.

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wor
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) BERLIN
STREET ADDRESS (If rural give location) MAIN ST.

3. NAME OF DECEASED: (Type or Print) (First) COVINGTON (Middle) DIRRICKSON (Last) Powell

4. DATE OF DEATH: (Month) January (Day) 15 (Year) 1954

5. SEX: Male
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): MARRIED
8. DATE OF BIRTH: DEC. 7, 1887
9. AGE last birthday: 66 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: MANAGER & OWNER MILL
10b. KIND OF BUSINESS OR INDUSTRY: THE ADKINS CO.
11. BIRTHPLACE (State or foreign country): POWELLVILLE MD
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: JOHN L. POWELL
14. MOTHER'S MAIDEN NAME: SALLY ELIZABETH RAYNE

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service) No
16. SOCIAL SECURITY No.:
17. INFORMANT & ADDRESS: MR ROLAND POWELL, BERLIN, MD

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Artery Thrombosis
DUE TO
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) Coronary Atherosclerosis
DUE TO
(c)

Interval Between Onset And Death: 6 weeks

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION:
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12/2/, 1953, to 1/15/, 1954 that I last saw the deceased alive on 1/15/, 1954, and that death occurred at 3 45 pm from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D.
ADDRESS Salisbury Md.
DATE SIGNED Jan. 15 1954

23. BURIAL, CREMATION, REMOVAL (Specify) BURIAL
DATE THEREOF 1/18/54
NAME OF CEMETERY OR CREMATORY BUCKINGHAM
LOCATION (City, town, or county) BERLIN (State) MD.

DATE REC'D BY LOCAL REGISTRAR 1-19-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Anna A Burbage
ADDRESS Berlin Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN 21 [illegible]
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: Please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury
LENGTH OF STAY (in this place) 6 Weeks
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hosp.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland — COUNTY Worchester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Snow Hill
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) J. (Middle) Luther (Last) Powell

4. DATE OF DEATH: (Month) January (Day) 28 (Year) 1954

5. SEX: male

6. COLOR OR RACE: white

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married

8. DATE OF BIRTH: Aug. 27 - 1891

9. AGE last birthday: 62-5-1 yrs. IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Gracey Store

11. BIRTHPLACE (State or foreign country): Belle Haven, Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: John H. Powell

14. MOTHER'S MAIDEN NAME: Emma L. Duncan

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) No (If Yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 227-10-9065

17. INFORMANT & ADDRESS: Mrs Ora L Powell, Snow Hill, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Myocardial Infarction, acute — Interval Between Onset And Death: 10 days

DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b) Arteriosclerotic coronary thrombosis — "

DUE TO

(c)

420.1

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION — 20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 12-17, 1953, to 1-28, 1954, that I last saw the deceased alive on 1-28, 1954, and that death occurred at 6:20 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title) — ADDRESS — DATE SIGNED

William R. Ellis M.D. — Salisbury, Md. — 1-29-54

22. BURIAL, CREMATION, REMOVAL (Specify) Burial — DATE THEREOF Jan. 30/54 — NAME OF CEMETERY OR CREMATORY Whatcoat — LOCATION (City, town, or county) Snow Hill — (State) Md

DATE REC'D BY LOCAL REGISTRAR 2-1-54 — REGISTRAR'S SIGNATURE Mary W. Holloway

24. FUNERAL DIRECTOR — ADDRESS

Elliott Dennis, Snow Hill, Md

VS. A15

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BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 Reg. Dist.

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury / — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Emroute to Hospital X

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland COUNTY Dorchester
CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN Vienna 01X-2
STREET ADDRESS (If rural, give location) ✓

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| HANNIBAL | HAMLIN | REID | Jan. | 22 | 1954 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR Months | Days | IF UNDER 24 HRS. Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Male | White | Married | 7/16/25 | 28 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| DuPont Nylon worker | | Vienna, Md. | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Hannibal Reid | Esna Day |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| / | | Hannibal Reid |

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| 816X Immediate cause | (a) Fractured skull and brain injury | Sudden |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | (b) DUE TO crushed chest | Sudden |
| | (c) DUE TO | |

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDING OF OPERATION: | 20. AUTOPSY? Yes ☐ No ☐ |
|---|---|---|
| 0 | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH. | 21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY | 21c. (City or town) | (County) | (State) |
|---|---|---|---|---|
| | Highway | Salisbury | Wicomico | Maryland |

| 21d. TIME OF INJURY (Month) | (Day) | (Year) | (Hour) | 21e. INJURY OCCURRED While at work ☐ | Not while at work ☒ | 21f. HOW DID INJURY OCCUR? |
|---|---|---|---|---|---|---|
| 1 | 22 | 54 | 3AM. | | / | Auto and truck collision |

22. I hereby certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and find that death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined cause ☐.

SIGNATURE F A Rademaker M. D. CHIEF MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☒ ASSISTANT MEDICAL EXAM. ☐ DATE SIGNED 1/23/54

| 23. BURIAL, CREMATION, REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | 1/24/54 | Reids Grove Cemetery | Reids Grove-Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-25-54 | Mary M. Holloway | Ruth S. McLaughlin | |

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15A - 5 - 53

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BUREAU [illegible]

1079

MARYLAND STATE DEPARTMENT OF HEALTH

# CERTIFICATE OF DEATH
## FOR MEDICAL EXAMINERS

Dr. Charles Fisher
Asst: Med. Exam.

Reg. Dist. No. 332

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct answer is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS. A15A

1. PLACE OF DEATH — COUNTY: Salisbury, Wicomico — MARYLAND — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Rural Salisbury — LENGTH OF STAY (In this place): several days — HOSPITAL OR INSTITUTION OR STREET ADDRESS: Route #13 Md. Motel

2. USUAL RESIDENCE (HOME) OF DECEASED — STATE: Kentucky — COUNTY: Campbell — CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Newport — STREET ADDRESS (If rural, give location): 3 East Third St.

3. NAME OF DECEASED (Type or Print): (First) GEORGE (Middle) W. SANDERS

4. DATE OF DEATH: (Month) Jan (Day) 21 (Year) 1954

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Married

8. DATE OF BIRTH: Jan. 27, 1898

9. AGE Last birthday: 55 — If under 1 year: Months — Days — If under 24 hrs.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck driver

10b. KIND OF BUSINESS OR INDUSTRY: Refrigerated Food Co.

11. BIRTHPLACE (State or foreign country): Kenton Co. Kentucky

12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: William Sanders

14. MOTHER'S MAIDEN NAME: No Record

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Unk — (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT AND ADDRESS: Mrs. Louise Sanders (Wife) #3 East Third St Newport, Kentucky

### 18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Coronary Disease — Interval between onset and death: Sudden

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) (c)

II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? Yes ☐ No ☒

21. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH. | PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY | (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. | INJURY OCCURRED While at work ☐ Not while at work ☐ | HOW DID INJURY OCCUR?

22. *I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑ thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased died on the day stated above, and death in my opinion resulted from: natural causes ☑, accident ☐, suicide ☐, homicide ☐, undetermined ☐.*

SIGNATURE (Degree or title): Chas G. Fisher, M.D. — ADDRESS: 200 N. Division St Salisbury Md. — DATE SIGNED: 1/21/54

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 25, 1954 — NAME OF CEMETERY OR CREMATORY: Ever Green Cemetery — LOCATION (City, town, or county) (State): South Gate Kentucky

DATE REC'D BY LOCAL REG.: 1-21-54 — REGISTRAR'S SIGNATURE: Mary L. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

Walter R. Holloway

BUREAU V. S.

1073

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven
LENGTH OF STAY (in this place) 36 yrs
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) White Haven
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) SARAH (Middle) ELIZABETH (Last) SHORES
4. DATE OF DEATH: (Month) Jan. (Day) 25 (Year) 1954

5. SEX: Female
6. COLOR OR RACE: White
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Married
8. DATE OF BIRTH: Nov. 13, 1874
9. AGE last birthday: 79 yrs. IF UNDER 1 YEAR Months 2 Days 12 IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired) Housework
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: John Owens
14. MOTHER'S MAIDEN NAME: unknown

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unk.) If No (If Yes, give war or dates of service) —
16. SOCIAL SECURITY No.: —
17. INFORMANT & ADDRESS: Edward Shores - White Haven, Md

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause (a) Chronic Heart Failure — Interval Between Onset And Death: 1 year.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Cortero sclerotic Heart Disease — 7 years.

DUE TO (c)

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. Insanitive — 3 months

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 15 Mar 1947, to 25 Jan., 1954; that I last saw the deceased alive on 25 Jan, 1954, and that death occurred at 12 45 P.M., from the causes and on the date stated above.

SIGNATURE Richard H. Saunders (Degree or title) M.D. ADDRESS Nanticoke Md. DATE SIGNED 25 Jan 54.

23. BURIAL, CREMATION, REMOVAL (Specify) Burial DATE THEREOF 1/27/54 NAME OF CEMETERY OR CREMATORY Bevalve Cemetery LOCATION (City, town, or county) Bevalve (State) Md.

DATE REC'D BY LOCAL REGISTRAR 1-27-54 REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR Cornelius D. Nissen ADDRESS Bevalve, Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

RECEIVED
JAN [illegible] 1954
BUREAU V. S.

Dr. Sohler

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 Salisbury
LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS 519 Priscella St. X

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Virginia COUNTY Grayson
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Fries Va.
STREET ADDRESS (If rural, give location) R.D. # 1

**3. NAME OF DECEASED:** (Type or Print) (First) JOHN (Middle) WILLIAM (Last) SHUPE

**4. DATE OF DEATH:** (Month) JAN (Day) 28 (Year) 19 54

**5. SEX:** Male

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify): Married

**8. DATE OF BIRTH:** Oct. 7, 1878

**9. AGE last birthday:** 75 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired) Retired Laborer

**10b. KIND OF BUSINESS OR INDUSTRY:** Textile Worker

**11. BIRTHPLACE** (State or foreign country): Hillsville Va.

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** William Shupe

**14. MOTHER'S MAIDEN NAME:** Maggie Ruse

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) Unk (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Mr. Posey A. Shupe (Son) 519 Priscella St. Salisbury, Maryland

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: 151X

Immediate cause (a) Cancer of stomach — INTERVAL BETWEEN ONSET AND DEATH ?

DUE TO

Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death. Anemia secondary ?

**19a. DATE OF OPERATION:** 0

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☒

**21. ACCIDENT SUICIDE HOMICIDE** (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec, 1953, to Jan 28, 1954, that I last saw the deceased alive on Jan 27, 1954, and that death occurred at 9:40 A. m., from the causes and on the date stated above.

SIGNATURE H. Sohler (DEGREE OR TITLE) M.D. ADDRESS Delmar, Maryland DATE SIGNED Jan. 30. 1954

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial

DATE THEREOF Jan. 31, 1954

NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park

LOCATION (City, town, or county) Salisbury, Maryland (State)

DATE REC'D BY LOCAL REG. 1-31-54

REGISTRAR'S SIGNATURE Mary W. Holloway

**24. FUNERAL DIRECTOR** HOLLOWAY & COMPANY SALISBURY MARYLAND ADDRESS

Walter R. Holloway

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

RECEIVED
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BUREAU V. &

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Salisbury — LENGTH OF STAY (in this place)
HOSPITAL OR INSTITUTION OR STREET ADDRESS Peninsula General Hospital

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Maryland. — COUNTY Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Mardella
STREET ADDRESS (If rural give location)

**3. NAME OF DECEASED:** (Type or Print) (First) (Middle) Smith (Last)

**4. DATE OF DEATH:** (Month) January (Day) 21 (Year) 1954

**5. SEX:** Female

**6. COLOR OR RACE:** White

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):**

**8. DATE OF BIRTH:** January 21-54

**9. AGE** Last Birthday: yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 3 hrs, Min.

**10a. USUAL OCCUPATION.** Give kind of work done during most of working life, even if retired):

**10b. KIND OF BUSINESS OR INDUSTRY:**

**11. BIRTHPLACE** (State or foreign country): Maryland

**12. CITIZEN OF WHAT COUNTRY?** USA

**13. FATHER'S NAME:** George William Smith

**14. MOTHER'S MAIDEN NAME:** Etta Marie Dunn

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No — (If Yes, give war or dates of service)

**16. SOCIAL SECURITY NO.:**

**17. INFORMANT & ADDRESS:** Etta Marie Smith

**18. MEDICAL CERTIFICATION**

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

7767
Immediate cause (a) Prematurity (autopsy diagnosis)
DUE TO

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
(b)
DUE TO
(c)

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:** —

**19b. MAJOR FINDINGS OF OPERATION** —

**20. AUTOPSY?** Yes ☒ No ☐

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 1/21/, 1954, to 1/21/, 1954, that I last saw the deceased alive on 1/21/, 1954, and that death occurred at 5:12 A.M. from the causes and on the date stated above.

SIGNATURE (Degree or title) ADDRESS DATE SIGNED
Robert Lee Baker MD Salisbury Md 1-22-54

**23. BURIAL, CREMATION, REMOVAL** (Specify) — DATE THEREOF 1-22-54 — NAME OF CEMETERY OR CREMATORY Peninsula General Hospital — LOCATION (City, town, or county) Salisbury Wicomico (State) Md

DATE REC'D BY LOCAL REGISTRAR 1-22-54 — REGISTRAR'S SIGNATURE Mary M Holloway

**24. FUNERAL DIRECTOR** Peninsula General Hospital — ADDRESS

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JAN 25 1934
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Rt. # 1 X
LENGTH OF STAY (in this place) All life
HOSPITAL OR INSTITUTION OR STREET ADDRESS At home ✓

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE Md. COUNTY Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Salisbury, Rt. # 1
STREET ADDRESS (If rural, give location)

**3. NAME OF DECEASED:** (Type or Print) (First) Hester (Middle) Amelia (Last) Stanford

**4. DATE OF DEATH:** (Month) 1 - (Day) 6 - (Year) 1954

**5. SEX:** Female

**6. COLOR OR RACE:** A.A.

**7. SINGLE, MARRIED, WIDOWED, DIVORCED,** (Specify) married

**8. DATE OF BIRTH:** About 1884

**9. AGE last birthday:** About 70 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

**10a. USUAL OCCUPATION** (Give kind of work done during most of working life, even if retired): Housewife

**10b. KIND OF BUSINESS OR INDUSTRY:** At home

**11. BIRTHPLACE** (State or foreign country): Fruitland, Wicomico Co. Md.

**12. CITIZEN OF WHAT COUNTRY?** U.S.A.

**13. FATHER'S NAME:** Charlie Allen

**14. MOTHER'S MAIDEN NAME:** Mary Burris

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) No (If Yes, give war or dates of service) No

**16. SOCIAL SECURITY NO.:** None

**17. INFORMANT & ADDRESS:** Ernest Stanford, Salisbury, Md., Rt. # 1

**18. MEDICAL CERTIFICATION**

**I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:**

442X
Immediate cause (a) Cardio-Renal Vascular Disease — INTERVAL BETWEEN ONSET AND DEATH: About 2 yrs
DUE TO
Antecedent cause(s) (b)
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last
DUE TO
(c)

**II. OTHER SIGNIFICANT CONDITIONS:** Conditions contributing to the death but not related to the disease or condition causing death.

**19a. DATE OF OPERATION:**

**19b. MAJOR FINDINGS OF OPERATION:**

**20. AUTOPSY?** Yes ☐ No ☐

**21. ACCIDENT SUICIDE HOMICIDE** (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) M.
INJURY OCCURRED While at work ☐ Not while at work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct, 1953, to 1/5, 1954, that I last saw the deceased alive on 1/5, 1954, and that death occurred at 1:10 a.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) Chas T. Fisher None ADDRESS Salisbury, Md. DATE SIGNED 1/9/54

**23. BURIAL, CREMATION REMOVAL** (Specify): Burial
DATE THEREOF 1-10-'54
NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery
LOCATION (City, town, or county) (State) Fruitland, Wicomico Co., Md.

DATE REC'D BY LOCAL REG. 1-9-54
REGISTRAR'S SIGNATURE Mary W. Holloway

**24. FUNERAL DIRECTOR** Mary A. Stewart — ADDRESS 324 E. Church St. Salisbury, Md.

STEWART FUNERAL HOME

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BUREAU V. S.

1074

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

# CERTIFICATE OF DEATH

Reg. Dist. No. 01040

1. PLACE OF DEATH:
COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico X
LENGTH OF STAY (in this place) 77 years
HOSPITAL OR INSTITUTION OR STREET ADDRESS X

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE Maryland Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Quantico
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED: (Type or Print) (First) Clifford (Middle) A. (Last) Taylor Sr.
4. DATE OF DEATH: (Month) (Day) (Year) Jan. 31, 1954
5. SEX: male
6. COLOR OR RACE: white
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): married
8. DATE OF BIRTH: May 13, 1876
9. AGE last birthday: 77 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): Farming retired
10b. KIND OF BUSINESS OR INDUSTRY: ertired farmer
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Orlando Taylor
14. MOTHER'S MAIDEN NAME: Annie Byrd
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) no (If Yes, give war or dates of service) no
16. SOCIAL SECURITY No.: 215-20-4356A
17. INFORMANT & ADDRESS: Mrs Clifford Taylor Sr. Quantico, Md.

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause 420.1 (a) Coronary Artery Heart Disease — Interval Between Onset And Death 7¼ yrs.

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.
DUE TO (b) Coronary Atherosclerosis
DUE TO (c) Pulmonary emphysema
Chronic Bronchitis
Benign prostatic hypertrophy — 2 yrs.

11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0
19b. MAJOR FINDINGS OF OPERATION
20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE (Specify)
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) m.
INJURY OCCURED While at Work ☐ Not While At Work ☐
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Sept 10, 1946, to Jan. 31, 1954, that I last saw the deceased alive on Jan. 24, 1954, and that death occurred at ....., from the causes and on the date stated above.

SIGNATURE (Degree or title) David J. Gilmore M.D. ADDRESS Salisbury Md. DATE SIGNED Feb 3 1954

23. BURIAL, CREMATION, REMOVAL (Specify) Burial
DATE THEREOF 2-4-1954
NAME OF CEMETERY OR CREMATORY Quantico Cemetery
LOCATION (City, town, or county) (State) Quantico, Md.
DATE REC'D BY LOCAL REGISTRAR 2/3/54
REGISTRAR'S SIGNATURE Mary W. Holloway mpt
24. FUNERAL DIRECTOR Levin R. Wilson ADDRESS Princess Anne, Md.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

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3 5 1954
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1057

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Mann

# CERTIFICATE OF DEATH

Reg. Dist. No. 132

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town): Salisbury — LENGTH OF STAY (in this place): 1 yr
HOSPITAL OR INSTITUTION OR STREET ADDRESS: John B. Parsons Home for the Age.

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Worcester
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Snow Hill — 2 x 2
STREET ADDRESS (If rural, give location): R. D. #

3. NAME OF DECEASED: (First) MATTIE (Middle) ELLEN (Last) TRUITT

4. DATE OF DEATH: (Month) JAN (Day) 11 (Year) 18 54

5. SEX: Female

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): Widowed

8. DATE OF BIRTH: Sept. 17, 1864

9. AGE last birthday: 89 yrs. — IF UNDER 1 YEAR Months 3 Days 24 — IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired House

10b. KIND OF BUSINESS OR INDUSTRY: House Work

11. BIRTHPLACE (State or foreign country): Worcester Co. Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Ed Brimer

14. MOTHER'S MAIDEN NAME: Nancy Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT & ADDRESS: Mrs. Homer Mason Jr. Stockton, Maryland (Daughter)

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

Immediate cause — (a) Valvular Heart Disease (Arteriosclerotic) — Interval Between Onset and Death: 10 yrs

DUE TO

Antecedent cause(s) — Diseases or conditions, if any, giving rise to the above cause stating underlying cause last

(b)

DUE TO

(c)

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death: Fractured left femur which would not heal 8 mos

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION:

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M.

INJURY OCCURRED While at work ☐ Not while at work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from ..... 19..., to Jan 10 54, 19..., that I last saw the deceased alive on Jan. 6 54, 19..., and that death occurred at ..., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS — DATE SIGNED

James R Mann M.D. Broad Street Salisbury, Maryland Jan. 11 1954

23. BURIAL, CREMATION REMOVAL (Specify): Burial — DATE THEREOF: Jan. 13, 1954 — NAME OF CEMETERY OR CREMATORY: Whatcoate Cemetery — LOCATION (City, town, or county) (State): Snowhill Maryland

DATE REC'D BY LOCAL REG. 1-12-54 — REGISTRAR'S SIGNATURE: Maryll Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY — ADDRESS: SALISBURY MARYLAND

Walter R. Holloway

BUREAU V. S

1058

Dr. Wm Smith

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
COUNTY: Wicomico — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 613 Homer Street

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural give location): 613 Homer Street

**3. NAME OF DECEASED:** (Type or Print) (First) CARRIE (Middle) (Last) ULMAN

**4. DATE OF DEATH:** (Month) JAN (Day) 20 (Year) 19 54

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Dec. 2, 1887 | 66 yrs. | | | | |

| 10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired): | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country) | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | At own Home | Bridgeton New Jersey | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Azariah More | Laura Whitaker |

| 15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY No.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | | Mr. Frank Ulman (Husband) 613 Homer St. |

**18. MEDICAL CERTIFICATION** Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH — Interval Between Onset And Death

Immediate cause (a) Cardiac Failure

Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (b) Rheumatic Myocardial

DUE TO (c) damage.

II. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

| 19a. DATE OF OPERATION: | 19b. MAJOR FINDINGS OF OPERATION | 20. AUTOPSY? |
|---|---|---|
| | | Yes ☐ No ☒ |

| 21. ACCIDENT / SUICIDE / HOMICIDE (Specify) | PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | (CITY OR TOWN) | (COUNTY) | (STATE) |
|---|---|---|---|---|
| | | | | |

| TIME OF INJURY (Month) (Day) (Year) (Hour) | INJURY OCCURED While at Work ☐ Not While At Work ☐ | HOW DID INJURY OCCUR? |
|---|---|---|
| m. | | |

22. I hereby certify that I attended the deceased from 6-20, 1953, to 1-19, 1954, that I last saw the deceased alive on 1-19, 1954, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): W. B. Smith — ADDRESS: North Division Street Salisbury, Maryland — DATE SIGNED: Jan 22, 1954

| 23. BURIAL, CREMATION, REMOVAL (Specify) | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 22, 1954 | Parsons Cemetery | Salisbury, Maryland |

DATE REC'D BY LOCAL REGISTRAR: 1-21-54 — REGISTRAR'S SIGNATURE: Mary M Holloway

24. FUNERAL DIRECTOR — ADDRESS: HOLLOWAY & COMPANY SALISBURY MARYLAND

Walter R. Holloway

VS. A15

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Dr. Larmore

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

**1. PLACE OF DEATH:**
COUNTY: Wicomico — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
LENGTH OF STAY (in this place):
HOSPITAL OR INSTITUTION OR STREET ADDRESS: 410 Dover Street

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: Maryland — COUNTY: Wicomico
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: Salisbury
STREET ADDRESS (If rural, give location): 410 Dover Street

| 3. NAME OF DECEASED: (Type or Print) (First) | (Middle) | (Last) | 4. DATE OF DEATH: (Month) | (Day) | (Year) |
|---|---|---|---|---|---|
| BERNICE | MILDRED | WHAYLAND | JAN | 29 | 19 54 |

| 5. SEX: | 6. COLOR OR RACE: | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) | 8. DATE OF BIRTH: | 9. AGE last birthday: | IF UNDER 1 YEAR: Months | Days | IF UNDER 24 HRS.: Hours | Min. |
|---|---|---|---|---|---|---|---|---|
| Female | White | Married | Sept. 16, 1900 | 53 yrs. | | | | |

| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | 10b. KIND OF BUSINESS OR INDUSTRY: | 11. BIRTHPLACE (State or foreign country): | 12. CITIZEN OF WHAT COUNTRY? |
|---|---|---|---|
| House Wife | At Own Home | R. D. Delmar Maryland | USA |

| 13. FATHER'S NAME: | 14. MOTHER'S MAIDEN NAME: |
|---|---|
| Charles Haddock | Anna Tingle |

| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) | 16. SOCIAL SECURITY NO.: | 17. INFORMANT & ADDRESS: |
|---|---|---|
| No | | Mr. Wakeman W. Whayland (Husband) 410 Dover St. |

**18. MEDICAL CERTIFICATION** Salisbury, Maryland

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | Interval Between Onset and Death |
|---|---|---|
| Immediate cause | (a) Subarachnoid Hemorrhage | 5 days |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | DUE TO (b) | |
| | DUE TO (c) Essential hypertension and arteriosclerosis, to Uremia. | 2 yrs ± |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: — 19b. MAJOR FINDINGS OF OPERATION: — 20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify) — PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) M. — INJURY OCCURRED While at work ☐ Not while at work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Aug. 8, 19 53, to death, 19....., that I last saw the deceased alive on Jan. 29, 19 54, and that death occurred at 8:30 A.M., from the causes and on the date stated above.

| SIGNATURE | (DEGREE OR TITLE) | ADDRESS | DATE SIGNED |
|---|---|---|---|
| Ernest R. Larmore | M. D. | Delmar, Del | Jan. 30 1954 |

| 23. BURIAL, CREMATION REMOVAL (Specify): | DATE THEREOF | NAME OF CEMETERY OR CREMATORY | LOCATION (City, town, or county) (State) |
|---|---|---|---|
| Burial | Jan 31, 1954 | Wicomico Memorial Park | Salisbury Maryland |

| DATE REC'D BY LOCAL REG. | REGISTRAR'S SIGNATURE | 24. FUNERAL DIRECTOR | ADDRESS |
|---|---|---|---|
| 1-31-54 | Mary W. Holloway Walter R. Holloway | HOLLOWAY & COMPANY | SALISBURY MARYLAND |

Walter R. Holloway

VS. A15 8-51

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

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MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15 8-51

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 332

1. PLACE OF DEATH: COUNTY Wicomico MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Md.
LENGTH OF STAY (in this place) 10 mos.
HOSPITAL OR INSTITUTION OR STREET ADDRESS Deer's Head State Hospital

2. USUAL RESIDENCE (HOME) OF DECEASED: STATE Maryland COUNTY Somerset
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Princess Anne, Md. 19X-2
STREET ADDRESS (If rural, give location) Route #1 ✓

3. NAME OF DECEASED: (Type or Print) (First) Mary (Middle) E. (Last) White
4. DATE OF DEATH: (Month) 1 (Day) 9 (Year) 1954

5. SEX: F
6. COLOR OR RACE: W
7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): W
8. DATE OF BIRTH: 3/23/65
9. AGE last birthday: 73 58 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Dames Quarter, Md.
12. CITIZEN OF WHAT COUNTRY? Yes

13. FATHER'S NAME: Alfred McDaniel
14. MOTHER'S MAIDEN NAME: Rebecca Carew

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) Y (If Yes, give war or dates of service)
16. SOCIAL SECURITY NO.: ——
17. INFORMANT & ADDRESS: Hospital records

18. MEDICAL CERTIFICATION

I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:

| | | | Interval Between Onset and Death |
|---|---|---|---|
| Immediate cause | 420.0 | (a) Myocardial infarction | 30 min |
| | DUE TO | | |
| Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last | | (b) Arteriosclerotic heart disease | 10 y. |
| | DUE TO | | |
| | | (c) Arteriosclerosis generalized | ? |

II. OTHER SIGNIFICANT CONDITIONS: Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: —
19b. MAJOR FINDINGS OF OPERATION: —
20. AUTOPSY? Yes ☐ No ☑

21. ACCIDENT SUICIDE HOMICIDE (Specify) —
PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) (STATE)
TIME OF INJURY (Month) (Day) (Year) (Hour) — M.
INJURY OCCURRED While at work ☐ Not while at work ☐ —
HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 3/11, 1953, to 1/9, 1954, that I last saw the deceased alive on 1/13, 1954, and that death occurred at 2 40 A.m., from the causes and on the date stated above.

SIGNATURE (DEGREE OR TITLE) ADDRESS DATE SIGNED
J. P. Maldre, M.D. Salisbury Md. Deer's Head State Hosp. 1/9/54

23. BURIAL, CREMATION REMOVAL (Specify): Burial
DATE THEREOF 1/11/54
NAME OF CEMETERY OR CREMATORY Dames Quarter Cemetery
LOCATION (City, town, or county) Dames Quarter (State) Md.

DATE REC'D BY LOCAL REG. 1-12-54
REGISTRAR'S SIGNATURE Mary W. Holloway
24. FUNERAL DIRECTOR James Dinman
ADDRESS

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01045

Dr. Carrie Hearn

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
COUNTY: Wicomico — MARYLAND
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury
LENGTH OF STAY (in this place): 12
HOSPITAL OR INSTITUTION OR STREET ADDRESS: Gen. Gen. Hospital 20

2. USUAL RESIDENCE (HOME) OF DECEASED:
STATE: Maryland — COUNTY: Wicomico
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Salisbury 12
STREET ADDRESS (If rural give location): R.D. # 3 Shumaker Road

3. NAME OF DECEASED (Type or Print): (First) HARRY (Middle) LEE (Last) WILSON

4. DATE OF DEATH: (Month) JAN (Day) 19 (Year) 19 54

5. SEX: Male

6. COLOR OR RACE: White

7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): Divorced

8. DATE OF BIRTH: Oct. 20, 1888

9. AGE last birthday: 65 yrs. — IF UNDER 1 YEAR: Months 2 Days 29 — IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: Retired Farmer

10b. KIND OF BUSINESS OR INDUSTRY: Farming

11. BIRTHPLACE (State or foreign country): Salisbury, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: George Wilson

14. MOTHER'S MAIDEN NAME: Lavenia Hastings

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): Unk (If Yes, give war or dates of service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS: Mrs. Ora Wilson R.D. #3 Shumaker Road

18. MEDICAL CERTIFICATION — Salisbury, Maryland

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

153X
Immediate cause (a) Cardiac Failure — Interval Between Onset And Death

Antecedent causes (b) DUE TO: Arteriosclerosis (Generalized)
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) DUE TO: Cause of Infirmities

11. OTHER SIGNIFICANT CONDITIONS
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION: 0

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY? Yes ☐ No ☒

21. ACCIDENT / SUICIDE / HOMICIDE (Specify)

PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m.

INJURY OCCURED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Dec 3, 1953 to Jan 19, 1954 that I last saw the deceased alive on Jan 19, 1954 and that death occurred at 8:40 P.M., from the causes and on the date stated above.

SIGNATURE (Degree or title): Carrie L. Hearn M.D. ADDRESS: West Church St. Salisbury, Maryland DATE SIGNED: Jan. 21, 1954

23. BURIAL, CREMATION, REMOVAL (Specify): Burial — DATE THEREOF: Jan. 22, 1954 — NAME OF CEMETERY OR CREMATORY: Pollitt Family Cemetery — LOCATION (City, town, or county) (State): R.D.#3 Salisbury, Maryland

DATE REC'D BY LOCAL REGISTRAR: 1-21-54 — REGISTRAR'S SIGNATURE: Mary M. Holloway

24. FUNERAL DIRECTOR: HOLLOWAY & COMPANY SALISBURY MARYLAND — ADDRESS

Walter R. Holloway

VS. A15

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01046

# CERTIFICATE OF DEATH

Reg. Dist. No. 332

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

**1. PLACE OF DEATH:**
COUNTY: WICOMICO — STATE: MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SALISBURY
LENGTH OF STAY (in this place): 1 DAY
HOSPITAL OR INSTITUTION OR STREET ADDRESS: PENINSULA GENERAL HOSPITAL

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
STATE: MARYLAND — COUNTY: WICOMICO
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN: SALISBURY 12
STREET ADDRESS (If rural give location): 912 CAMDEN AVE

**3. NAME OF DECEASED:** (Type or Print) (First) CORA (Middle) GUSSIE (Last) WIMBROW

**4. DATE OF DEATH:** (Month) 1 (Day) 29 (Year) 1954

**5. SEX:** FEMALE

**6. COLOR OR RACE:** WHITE

**7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):** SINGLE

**8. DATE OF BIRTH:** JUNE 20, 1877

**9. AGE last birthday:** 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

**10a. USUAL OCCUPATION** Give kind of work done during most of working life, even if retired: BEAUTICIAN, RET

**10b. KIND OF BUSINESS OR INDUSTRY:** HAIRDRESSER

**11. BIRTHPLACE** (State or foreign country): MARYLAND

**12. CITIZEN OF WHAT COUNTRY?** U.S.A

**13. FATHER'S NAME:** JOSEPH H. WIMBROW

**14. MOTHER'S MAIDEN NAME:** LEAH K. WARD

**15. WAS DECEASED EVER IN U.S. ARMED FORCES?** (Yes, no, or unk.) NO (If Yes, give war or dates of service) —

**16. SOCIAL SECURITY No.:** 220-32-0884

**17. INFORMANT & ADDRESS:** Mrs Ralph Williams Same

**18. MEDICAL CERTIFICATION**

| | | Interval Between Onset And Death |
|---|---|---|
| I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | |
| 153X Immediate cause | (a) Shock - Postoperative | 10 hrs |
| Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. | DUE TO (b) Perforated Carcinoma of Caecum | 24 hrs |
| | DUE TO (c) Incisional Hernia | 2 years |
| II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. | | |

**19a. DATE OF OPERATION:** 1-28-54 — **19b. MAJOR FINDINGS OF OPERATION:** Perforated carcinoma of Caecum — **20. AUTOPSY?** Yes ☐ No ☑

**21. ACCIDENT / SUICIDE / HOMICIDE** (Specify) — **PLACE OF INJURY** (Home, farm, factory, street, office bldg., etc.) — (CITY OR TOWN) — (COUNTY) — (STATE)

TIME OF INJURY (Month) (Day) (Year) (Hour) m. — INJURY OCCURED While at Work ☐ Not While At Work ☐ — HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 11-28, 1954, to 1-29, 1954, that I last saw the deceased alive on 1/29, 1954, and that death occurred at 5:30 AM, from the causes and on the date stated above.

SIGNATURE (Degree or title): J.O. Cadenhead — ADDRESS: Salisbury Md — DATE SIGNED: 1-30-54

23. BURIAL, CREMATION, REMOVAL (Specify): BURIAL — DATE THEREOF: 1/31/54 — NAME OF CEMETERY OR CREMATORY: PARSONS CEMETERY — LOCATION (City, town, or county) (State): SALISBURY, MARYLAND

DATE REC'D BY LOCAL REGISTRAR: 1-31-54 — REGISTRAR'S SIGNATURE: Mary W. Holloway — 24. FUNERAL DIRECTOR: THE HILL & JOHNSON CO. — ADDRESS: SALISBURY

Franklin B Hill Jr.

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FEB 3 1954
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